Cochise Combined Trust

To All Covered Plan Members

The "COCHISE COMBINED TRUST", hereinafter called the Plan, assures the Covered Plan Members, during the continuance of this Plan, that all benefits hereinafter described shall be paid to them or on their behalf in the event the Covered Person incurs covered expenses as defined herein.

This Plan is subject to all the terms, provisions, conditions, and limitations stated on the pages hereof.

This revised Plan of benefits for the Cochise Combined Trust became effective as of 12:01 a.m. Mountain Standard Time on July 1, 2009.

Your Benefit Plan has been designed with many cost containment features to ensure that coverage can continue to be provided to you at a reasonable cost. You can assist in controlling costs by using this Plan and medical services responsibly and effectively. Some of the ways you can help are:

- Receive approval from American Health Group prior to receiving services that require pre-certification.
- Receive care from a provider in the network to maximize your benefits.
- Have surgery and x-ray/laboratory work done on an outpatient basis whenever possible.
- Use hospital emergency rooms only in the event of a serious medical emergency.
- Audit all Hospital and Physician billings and the Explanation of Benefits to be sure you and the Plan have only been billed for the services you received.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE

Choices that you make, or that are made on your behalf on account of a referral by your physician, which result in out-of-network charges or medically unnecessary care that is not payable by the Plan are YOUR responsibility.

A referral from an in-network provider to any out-of-network provider (i.e., laboratory, radiology, physician, etc.) does NOT make the claim from the out-of-network provider payable at the in-network rate.

Your Human Resources Department or Personnel Office and the Plan's Claims Administrator are available to answer questions and assist you in exploring options for coverage, but ultimately it is your responsibility to understand this Plan.

TAKE CARE OF YOURSELF. Eat right, control your weight, exercise, stop smoking, never drink and drive, and always wear your seat belt. Good habits will help you live a long, happy life and will save you money too!

QUICK REFERENCE INFORMATION

Group Number	CCG743
Plan Administrator	Cochise Combined Trust c/o 1115 Stockton Hill Road, Suite 101 Kingman, AZ 86401
Claims Administrator *(Claims & Benefit Information)*	Administrative Enterprises, Inc. (AEI) 5810 West Beverly Lane Glendale, Arizona 85306-1800 (602) 789-1170 (800) 762-2234 www.aeitpa.com
Description of Benefits/Eligibility	Administrative Enterprises, Inc. (AEI) www.aeitpa.com Fax: (602) 789-9369
Medical Review *(Pre-certification, Second Opinions)*	American Health Group (AHG) 2152 South Vineyard #103 Mesa, Arizona 85210 (602) 265-3800 (800) 847-7605
EPO/PPO Provider Network *(Names of Physicians & Hospitals in the Network)*	BlueCross BlueShield of Arizona P.O. Box 13466 Phoenix, Arizona 85002 (800) 232-2345 www.azblue.com
EPO/PPO for Mental Health Care	Cochise Health Systems (CHS) 1415 Melody Lane Bldg. A Bisbee, Arizona 85603 (520) 432-9600
Prescription Drug Program	Navitus Health Solutions, LLC 5 Innovation Court Appleton, WI 54914 (866) 333-2757 www.navitus.com
Plan Consultant and Privacy Officer	Erin P. Collins and Associates, Inc. 1115 Stockton Hill Road, Suite 101 Kingman, AZ 86401 (928) 753-4700

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PREFERRED PROVIDER ORGANIZATION (PPO)
JULY 1, 2009 THROUGH DECEMBER 31, 2009 ONLY

The Cochise Combined Trust has incorporated the BlueCross BlueShield of Arizona Preferred Provider Organization (PPO) as part of the benefit design.

A "PPO" is a group of hospitals, physicians, and other health care providers contracted to furnish medical care at negotiated rates. Use of PPO providers is referred to as "In-Network". By receiving your care and services from a provider in the above network, you will receive a higher level of benefits and therefore have less out-of-pocket expense.

When you need medical care, select a provider from your BCBSAZ directory or contact BlueCross Blue Shield of Arizona at (800) 232-2345 or online at "www.azblue.com" to verify the doctor's current status as a network provider. Your ID card identifies the BlueCross BlueShield of Arizona network and it should always be presented when obtaining services. The BCBSAZ provider will collect your co-payment the portion of the bill that is your responsibility and will submit your claim for payment consideration. AEI will process your benefits at the appropriate level and send you an "Explanation of Benefits" showing the payment calculation and the amount of "patient responsibility".

A current directory of the BlueCross BlueShield of Arizona contracted network providers will be given to you by your employer. If you choose a provider that is not part of this PPO network, benefits will be considered under the lower "Out-of-Network" benefits shown in the Schedule of Benefits.

If the need for medical care due to a life threatening emergency occurs outside the PPO network, services may be considered under the PPO "In-Network" Schedule of Benefits if it is determined by the Claims Administrator that immediate medical attention was required due to an accident or illness which is serious enough to constitute an "emergency" as defined in this document.

If your PPO physician needs to send you to another physician or admits you to a hospital, be sure that you are referred to a provider that participates in the applicable PPO network.

Cochise Combined Trust has also contracted with "Cochise Health Systems" (CHS) to provide professional services for mental health/substance abuse. These providers are in addition to the BlueCross BlueShield of Arizona Preferred Provider Organization mentioned above and will be paid at the In-Network percentage. CHS will offer access to contracted mental health providers in Cochise County only.

(BlueCross® BlueShield® of Arizona, an independent licensee of the BlueCross BlueShield Association, does not provide administrative or claims payment services. Cochise Combined Trust has assumed all liability for claims payments. No provider network benefits are available outside of Arizona)

EXCLUSIVE PROVIDER ORGANIZATION (EPO)
Effective January 1, 2010

The Cochise Combined Trust has incorporated the BlueCross BlueShield of Arizona Exclusive Provider Organization (EPO) as part of the benefit design. An EPO is a group of hospitals, physicians, and other health care providers contracted to furnish medical care at negotiated rates. The EPO providers are listed as BCBSAZ "Preferred Care" and "Participating Only" providers.

Use of EPO providers is **required** to receive the benefits described in this book. All services received in Arizona must be rendered by a BlueCross Blue Shield of Arizona network provider or benefits will not be available (except in the case of a life threatening emergency).

When you need medical care, select a provider and/or facility from your BCBSAZ directory or contact BlueCross Blue Shield of Arizona at (800) 232-2345 or online at "www.azblue.com" to verify current status as a network provider/facility. Your ID card identifies the BlueCross BlueShield of Arizona network and it should always be presented when obtaining services. The BCBSAZ provider will collect the portion of the bill that is your responsibility and will submit your claim for payment consideration. The Claims Administrator (AEI) will process your benefits at the appropriate level and send you an "Explanation of Benefits" showing the payment calculation and the amount of "patient responsibility".

A current directory of the BlueCross BlueShield of Arizona contracted network providers will be given to you by your employer. If you choose a provider that is not part of this EPO network, benefits will not be available (except in the case of a life threatening emergency).

If the need for medical care due to a life threatening emergency occurs outside the EPO network, services may be considered under the EPO Schedule of Benefits if it is determined by the Claims Administrator that immediate medical attention was required due to an accident or illness which is serious enough to constitute an "emergency" as defined in this document.

If the plan member's temporary or permanent place of residence is not in the state of Arizona, only life threatening emergency care will be considered under the EPO Schedule of Benefits.

If your EPO physician needs to send you to another physician or admits you to a hospital, be sure that you are referred to a provider/facility that participates in the applicable EPO network.

Cochise Combined Trust has also contracted with "Cochise Health Systems" (CHS) to provide professional services for mental health/substance abuse. These providers are in addition to the BlueCross BlueShield of Arizona Exclusive Provider Organization mentioned above and will be considered under the EPO Schedule of Benefits. CHS will offer access to contracted mental health providers in Cochise County only.

MEDICAL REVIEW / PRE-CERTIFICATION

This Plan has contracted with American Health Group (AHG) to provide medical review, and pre-certification of selected services. AHG will review proposed medical services to determine their medical necessity and appropriateness. It is always up to you and the physician you choose to determine what services you need and who will provide your care, regardless of what this Plan will pay for.

This program is designed as a cost containment measure to maximize the Plan benefits and reduce unnecessary hospitalizations, surgical procedures, and other diagnostic services. Once a pre-certification is received, it is valid for ninety (90) days. Failure to comply with the pre-certification requirements may result in a three hundred dollar ($300) penalty or may disqualify the Covered Person for benefits.

IMPORTANT: Pre-certification of a procedure does <u>not</u> guarantee benefits. All benefit payments are determined by Administrative Enterprises, Inc. in accordance with the provisions of this Plan.

1. *Pre-certification is required on the following:*
   Diagnostic tests and surgical procedures over one thousand dollars ($1,000)
   All non-emergency Hospital admissions (emergency within 48 hours)
   Admissions to skilled nursing/rehabilitation facilities
   Maternity admissions that exceed forty-eight (48) hours, (96 hours for Cesarean Section)
   Hospice facility admissions
   Psychological and neuropsychological testing
   Occupational, Speech and Physical Therapy treatment programs (*penalty applied per condition*)

2. *Procedure for obtaining pre-certification:*
   a. For all non-emergency procedures that require pre-certification, the Covered Person or his/her Physician must contact AHG prior to the admission or in advance of the procedure. It is recommended that pre-cert is requested at least seventy-two (72) hours in advance. AHG will review the request for services and contact the Physician for any records or additional information necessary to thoroughly evaluate the need for services. Benefit eligibility for the pre-certified procedures must be verified with AEI prior to completing services
   b. For emergency procedures or hospital admissions, the Covered Person, his/her Physician, the hospital admissions clerk, or anyone associated with the Covered Person's treatment, must notify AHG by telephone within forty-eight (48) hours of the procedure or the admission.

3. *Second Surgical Opinions*
   Before approval of a requested surgical procedure, AHG may require the Covered Person to obtain a second opinion. AHG will provide the Covered Person with the name of one or more Physicians that can provide the second opinion.

4. *Case Management*
   In certain complex medical situations, case management may become necessary. A case manager will be assigned to work with the patient, the family, the Physician and the claims payer to coordinate an effective treatment plan.

5. *Appeal / Reconsideration Procedures*
   You may appeal any recommendation made by this medical review program. The appeal must be made in writing directly to American Health Group. You can expect a response within thirty (30) days of your request unless it is necessary to obtain additional medical records.

"AHG" may be reached at: (602) 265-3800 or (800) 847-7605
2152 South Vineyard #103
Mesa, Arizona 85210

Benefit Eligibility is obtained through AEI at: <u>www.aeitpa.com</u> or via fax at (602) 789-9369

ARTICLE I

Schedule of Benefits for Cochise Combined Trust

EFFECTIVE JANUARY 1, 2010, USE OF EPO PROVIDERS WILL BE REQUIRED FOR ALL BENEFITS

1.01 LIFETIME MEDICAL/Rx MAXIMUM $2,000,000

	In-Network	Out-of-Network 2009 ONLY
1.02 MEDICAL BENEFITS	(Subject to Co-pays)	(Subject to Deductible)
Physician Office Services: *(Exams, Surgery & X-ray/Lab under $500)*	$20 *co-pay*	50%
Outpatient Laboratory or Radiology *(Charges under $500)*	$20 *co-pay*	50%
Routine Physicals/Well Child Care *($500 max per Calendar Year)*	$ 0 *co-pay*	$ 0 *co-pay**
Allergy Injections *(When not part of an office visit)*	$ 0 *co-pay*	50%
Chiropractic Care *(20 visits per Cal Year; $40 max payable per visit)*	$20 *co-pay*	50%
Maternity Initial Visit to confirm pregnancy	$20 *co-pay*	50%
Prenatal/Postnatal Office Visits	$ 0 *co-pay*	50%
Urgent Care Centers	$25 *co-pay*	50%
Vision Care *(One Exam per Calendar Year)*	$20 *co-pay*	$25 benefit
Vasectomy *(Allowed in-office only)*	$20 *co-pay*	50%
Routine Colonoscopies *(Over age 50 & covered once every 10 years)*	$ 0 *co-pay*	
		*deductible waived
1.03 DEDUCTIBLES		
Individual Deductible per Calendar Year	$250	$500
Family Deductible per Calendar Year	$750	$1,500
1.04 SERVICES SUBJECT TO DEDUCTIBLES		
Inpatient Hospital Services	80%	50%
Inpatient Physician Visits	80%	50%
Surgery / Physician	80%	50%
Anesthesia	80%	50%
Maternity (Delivery and Facility)	80%	50%
Hospital Emergency Room ($50 *co-pay; Waived if admitted)*	80%	80%
Ambulatory Surgical Facility	80%	50%
Complex Laboratory or Radiology *(Single test over $500 allowable)*	80%	50%
Cardiac Cath Lab	80%	50%
Second Surgical Opinions *(When required by AHG/deductible waived)*	100%	100%
Ambulance Service *(Deductible waived)*	80%	80%
Tubal Ligation	80%	50%
Durable Medical Equipment *($1,000 maximum per item)*	80%	50%
Radiation/Chemotherapy/Dialysis	80%	50%
Rehabilitative & Physical Therapy	80%	50%
Home Health Care *(60 days per Calendar Year)*	80%	50%
Skilled Nursing Facility *(90 days per Calendar Year)*	80%	50%
Hospice Care *(60 days per 12 consecutive months)*	80%	50%
All other Eligible Expenses	80%	50%
1.05 ANNUAL OUT-OF-POCKET MAXIMUM *(Out-of-Pocket Maximums are per person)*	$1,500	None

1.06 HEARING AID BENEFIT

Hearing Examination/Testing	$15 co-pay
Hearing Aid *(One every three years)*	50% *(subject to medical deductible)*
Maximum Payable	$1,000

1.07 MENTAL HEALTH CARE / CHEMICAL DEPENDENCY / SUBSTANCE ABUSE

		In-Network	Out-of-Network 2009 ONLY
Inpatient	*30 days maximum per Calendar Year* *2 confinements per Lifetime*	80%	50%
Outpatient		$20 *co-pay*	50%
Psychological/Neuropsychological Testing		50%	

1.08 PRESCRIPTION DRUG CARD

Retail Pharmacy	Up to a 30 day supply:	Tier 1	$ 10 co-pay
		Tier 2	$ 30 co-pay
		Tier 3	$ 60 co-pay
		Specialty Drugs	$ 75 co-pay
Retail 90	Up to a 90 day supply:	Tier 1	$ 10 co-pay
		Tier 2	$ 60 co-pay
		Tier 3	$120 co-pay
Mail Order	Up to a 90 day supply:	Tier 1	$ 10 co-pay
		Tier 2	$ 60 co-pay
		Tier 3	$120 co-pay

Note: All Proton Pump Inhibitors (ie: Nexium, Prevacid, etc) are covered at 50%

Generic Drug: Is simply the chemical name of a brand-name drug for which the patent has expired allowing for a lower cost generic equivalent to be produced. Generic medications are typically covered in Tier 1

Preferred Brand Drug: Is a brand-name drug on the formulary. Preferred Brands are typically covered in Tier 2

Non-Preferred Brand Drug: Is a brand-name drug not listed on the formulary or a brand-name drug with a generic available. Non-Preferred Brands are typically covered in Tier 3.

Formulary: Is a list of medications that can help you and your physician to maximize your benefits while minimizing overall prescription drug costs to you or the Plan. The formulary used by CCT is subject to periodic review and updating by the contracted pharmacy benefit management company.

Specialty Pharmacy Drugs: Are biotech drugs to treat chronic, serious, or rare disease. In most cases these drugs are delivered by injection or infusion requiring complex care, special storage and handling, strict compliance requirements, or extra patient support. Some health conditions are, but not limited to, Crohn's disease, growth hormone deficiency, multiple sclerosis, rheumatoid arthritis, solid organ transplant, and viral hepatitis.

1.09 DENTAL BENEFITS

Dental Deductible*	
Individual Deductible per Calendar Year	$50
Family Deductible per Calendar Year	$150
**Deductibles do not apply to Preventive or Orthodontics*	
Maximum Benefit *(All dental services combined, excluding orthodontia apply to max)*	$1,500 per person per calendar year
Preventive Dental -Cleanings (2x/year) -Oral Exams (2x/year) -Fluoride (Children under age 17 – 2x/year) -X-rays (Bitewing – one set per calendar year) (Full mouth-one every 36 months) -Space Maintainers (Under age 14) -Emergency Palliative Treatment (When no other treatment is given)	100%*
Basic Dental -Fillings -Extractions -Endodontics (root canals) -Oral Surgery -Periodontics (gum disease) -Sealants (to age 19 - Permanent bicuspids and molars, 1x/3 years)	80%
Major Dental -Dentures -Bridges -Inlays -Crowns -Implants	50%
Orthodontics	50%*
Maximum lifetime Benefit	$1,000
Age limit	Children banded by age 17 only

1.10 SHORT TERM DISABILITY (County Employees Only)

Waiting Period	45 Calendar days of Total Disability*
Benefits Payable	
Percentage Payable	60% of Salary
Minimum Payable	$100 Per Week
Maximum Days Payable	135 Calendar Days
Survivor Benefit	30 Calendar Days
Pre-Existing Conditions	Same Exclusions as Medical Plan
Offsets	Other Group STD Social Security Disability No Fault Auto Insurance Rehabilitation Income

*45 days and after all accrued paid leave has been exhausted

ARTICLE II

ELIGIBILITY / EFFECTIVE DATE

2.01 ***Eligible Employee:*** All benefit eligible positions as determined by the participating employer of the Cochise Combined Trust, provided the employee regularly works a minimum of twenty (20) hours per week at their customary place of employment and performs all of the duties of their employment.

2.02 ***Eligible Retirees:***

A covered Cochise College Employee will be eligible to continue coverage on this Plan as a Retiree until the earlier of eligibility for Medicare or until the age of sixty-five (65) provided:

a] The employee is fifty-five (55) years of age and has met the terms and conditions of regular retirement with the Arizona State Retirement System and has completed ten (10) consecutive years of benefit eligible employment with Cochise College immediately prior to retirement; or

b] The employee has eighty (80) points of age and credited service with the Arizona Retirement System and has completed ten (10) consecutive years of benefit eligible employment with Cochise College immediately prior to retirement; and

c] The retiree continues to make all required contributions to cover the full cost of coverage for the retiree and any eligible dependents.

A covered Cochise County Employee, will be eligible to continue coverage under this Plan as a Retiree until the earlier of eligibility for Medicare or until the age of sixty-five (65) provided:

a] The Retiree has completed no less than fifteen (15) consecutive and continuous years of employment with Cochise County in a position that was eligible for medical benefits coverage under the Plan on the effective date of retirement; and

b] The Retiree has met all the terms and conditions for eligibility for retirement from Cochise County and the Arizona Public Employee Retirement System which applies to them (i.e., ASRS, PSPRS, EORP or CORP) (the "Applicable Retirement System") and have in fact actually retired under the Applicable Retirement System; and

c] The Retiree is actually receiving, and continues to receive, pension benefits from the Applicable Retirement System beginning from the effective date of retirement from Cochise County; and

d] The Retiree, either as a retiree or as a dependent of a non-retired and active Cochise County Employee, remains on the Plan continually without a break in coverage from the effective date of retirement; and

e] The Retiree makes the required Retiree contributions to receive benefits as a retiree by the fifteenth (15^{th}) of the month or the active employee pays the required contributions for dependent coverage, whichever is applicable. Failure to remit payment by the due date will result in cancellation of coverage without notice; and;

f] The Retiree signs the required form to waive COBRA coverage.

If the Retiree is obtaining medical benefits under the Plan as a Retiree only, and not as a Retiree obtaining benefits as a dependent of a non-retired and active Cochise County employee, the following dependent coverage eligibility applies:

a] A dependent spouse of a Cochise County retiree is eligible to continue their coverage as a dependent of the Plan provided they were covered on the date the Covered Employee became a retiree. Coverage will be provided through the earlier of the date the Spouse of the Retiree dies, reaches Medicare eligibility or the age of sixty five (65), as long as the following are met:

1. As long as the Spouse of the Retiree continues to meet all other provisions of the County Medical plan pertaining to eligibility for Dependent coverage; and

2. The Retiree or Spouse continues to make the required contributions in a timely manner as determined by the County's medical plan provider.

b] Dependent Children of Cochise County retirees are eligible to continue their coverage as dependents after their County Employee parent(s) retire provided:

1. They were covered as Dependent Children on the date of the Covered Employee's retirement as provided herein through the earlier of the date the Child of the retiree dies, becomes Medicare eligible or otherwise no longer qualifies as a dependent child under the provisions of this Plan that are applicable to the dependent children of employees, and
2. The Retiree or Child continues to make the required contributions in a timely manner as determined by the County's medical plan provider.

c] If a Retiree's dependent spouse or dependent child(ren) terminates coverage for any reason, coverage cannot be reinstated at a later date.

Dependents of a Covered Retiree are eligible for coverage provided they were covered dependents of this Plan immediately prior to the date of the Covered Employee's retirement, or who qualify for addition to the Plan under applicable provisions of the federal Health Insurance Portability and Accountability Act (HIPAA). If a Retiree's coverage terminates for any reason, coverage cannot be reinstated at a later date.

2.03 ***Leave of Absence:*** If a Covered Employee is granted an approved leave of absence by either Cochise County or Cochise College, the Covered Employee and his/her dependents will be allowed to remain eligible on this Plan during the approved leave, provided any required contributions are made on the established due date each month. Eligibility under an approved leave is for a maximum of six (6) months. If the Covered Employee's leave continues beyond six (6) months, coverage can be continued under the COBRA provisions of this Plan (reference Article IV for additional COBRA information).

2.04 ***Initial Enrollment:*** All new Cochise County employees will be covered on the first day of the month following the date of full-time employment. All new Cochise College employees will be covered on the first day of the month of active employment following Governing Board approval of hire, with the exception of new faculty who may be covered (after obtaining Governing Board approval for hire) on the first day of the month during which instruction and active employment begins. Coverage will be effective provided proper enrollment has been made and any required contributions have been authorized.

2.05 ***Eligible Dependents:*** Eligible dependents shall include a Covered Employee's or a Covered Retiree's:

a] Lawful spouse to whom the Covered Employee is married pursuant to and as permitted by Arizona law, provided they are not legally separated;

b] Unmarried children, including legally adopted children (from the date of placement in the employee's home for the purpose of adoption), until their nineteenth (19^{th}) birthday.

c] The following children under the age of nineteen (19) will also be considered as eligible dependents provided their primary residence is with the ***employee***, and the employee or the employee's spouse is legally responsible to provide medical care:

1] Stepchild;
2] Lawfully placed foster child for whom coverage is not available through a state agency;
3] A child who is under the legal guardianship of the employee substantiated by a court order.

d] Unmarried dependent children nineteen (19) years of age but less than twenty-four (24) years of age, provided they are a full-time student (as defined by the institution they are attending) in high school or at an accredited university, college, vocational or other institution of higher learning, and they are dependent upon the employee for principal financial support. If a dependent student has completed the spring semester at their school, eligibility will continue through the months of June, July and August. However, once a student graduates they are no longer an eligible dependent and coverage ceases at the end of the month in which they graduate. Documentation of student status will be required by the Claims Administrator before benefits will be considered.

Note: Dependent eligibility under this Plan may be different than the definition of a qualified dependent by the IRS, and as such dependent coverage for certain dependents may be subject to taxation.

2.06 ***Eligibility Restrictions:*** An employee may not be covered under this Plan as both an employee and as a dependent. If both a husband and a wife are Covered Employees, dependent children can be covered under this Plan by either parent, but ***not*** by both parents. An employee may not enroll their dependents without enrolling themselves in the Plan.

2.07 ***Disabled Dependents:*** An unmarried child who has reached the specified age limit will continue to be eligible if the child is:

a] Incapable of self-support due to a mental or physical handicap; and
b] Became handicapped prior to the attainment of age nineteen (19), or age twenty-four (24) if they were a full-time student; and
c] The Plan is provided with proof of the child's disability and continued dependency within thirty-one (31) days prior to termination of the child's dependent status.

The Plan may require the Covered Employee to obtain a Physician's statement certifying the physical or mental disability prior to approval and at reasonable intervals thereafter.

2.08 ***Dependents Effective Date:*** If an employee has eligible dependents when his or her coverage begins, dependent coverage will begin on the same day as the employee's, provided proper enrollment has been made and any required contributions have been authorized.

2.09 ***Newborn Dependents:*** Newborn children will be covered from the time of birth for necessary medical care ***only if***: a) the employee is carrying dependent coverage on the date of the baby's birth, or b) enrollment for dependent coverage is made *prior* to the baby's birth, or c) enrollment is made and required contributions are authorized within thirty-one (31) days of the date of birth. When enrolling for the dependent coverage, coverage is effective from the baby's date of birth and contributions for the dependent coverage are required beginning the first day of the month following the date of birth.

"Routine" newborn charges incurred at a Hospital (DRG 795) at the time of birth will be considered under the mother's coverage and paid as part of the mother's claim, whether or not dependent coverage is in effect.

2.10 ***Late Enrollment:*** Employees and dependents that do not enroll for coverage within thirty-one (31) days of their eligibility date are called late enrollees and subject to an eighteen (18) month Pre-Existing Condition limitation. Excluded from this provision are certain qualified family status changes (as stated in 2.12) if enrollment is made within thirty-one (31) days of the event. Dental benefits are not subject to the late enrollment Pre-Existing Condition limitation (see Article VI, section 6.02).

2.11 ***Special Enrollments for Newly Acquired Spouse or Dependent Child:***

a] If there are no eligible dependents when the employee's coverage begins, the employee can enroll a newly acquired spouse by marriage, or child by birth or adoption and/or any dependent children within thirty-one (31) days after he/she acquires the first eligible dependent.
b] If the employee is not enrolled in the Plan and then acquires an eligible dependent by marriage, birth or adoption, the employee can enroll themselves and/or any eligible dependent.
c] If the employee did not enroll their spouse when the spouse was initially eligible for coverage and the employee subsequently acquires an eligible dependent child, the spouse may be enrolled along with any dependent child.

For a, b & c above, coverage will be effective on the date the dependent is acquired, provided enrollment is completed within thirty-one (31) days of the acquisition of the eligible dependent.

Except for newborns and newly adopted children, anyone enrolling under these Special Enrollment provisions will be subject to the Pre-Existing Conditions Limitation.

2.12 ***Special Enrollments due to Loss of Other Coverage:*** Individuals that do not enroll in the Plan during their initial eligibility period because at the time they have other creditable coverage, and then they subsequently lose that coverage as a result of certain events such as termination of spouse's employment, loss of eligibility for coverage, expiration of COBRA coverage, reduction in the number of hours of employment, or employer contributions towards such coverage terminates, may now enroll in this Plan. Enrollment in this Plan must be completed within thirty-one (31) days of coverage termination from the other Plan. Coverage under this Plan will become effective on the first of the month following receipt of the enrollment. Failure to enroll under this Special Enrollment provision means you must follow the Open Enrollment or Late Enrollment provisions to enroll in this Plan.

2.13 ***Change of Status:*** If the Plan Member has any of the following qualifying change of status situations during the year, the Plan Member will be allowed to make a mid-year change in their coverage selections and change who is covered under the medical coverage:

a] Change in legal marital status: Marriage, divorce, legal separation, annulment, death of spouse.
b] Change in the number of dependents: Birth, adoption, or death of dependent child.
c] Change in employment status or work schedule: Start or termination of employment or change in employment status of the employee, their spouse or their dependent child.
d] Change in dependent status under the terms of this Plan: Age, or any other reason provided under the definition of an eligible dependent.
e] Change of residence or worksite: If the change impairs the Plan Member's ability to access the services of In-Network providers.
f] Change required under the terms of a Qualified Medical Child Support Order (QMCSO).
g] Eligibility for or cancellation of coverage under Medicaid, Medicare, or the Children's Health Insurance Program (CHIP)
h] Increase to the Employee in the cost of the benefits.
i] Significant changes in the benefits.
j] Changes in spouse's, former spouse's or dependent's coverage through their employer.

Three rules apply to making changes to the benefit selections during the year, otherwise the eligible employee or dependent will have to wait until Open Enrollment to make any change in the coverage:

a] Any changes to be made to the benefit selections must be necessary, appropriate to, and consistent with the change in status, and approved as such by the Plan Administrator or its designee; and
b] The Plan must be notified in writing within thirty-one (31) days of the qualifying change in status.
c] For changes in status related to 2.13(g) in this Section, the Plan must be notified in writing within sixty (60) days of the qualifying change in status.

2.14 ***OBRA/QMCSO:*** This Plan adheres to the Federal Omnibus Budget Reconciliation Act (OBRA) and Qualified Medical Child Support Orders (QMCSO), rules and regulations. If an employee's separated or divorced spouse or any state child support or Medicaid agency has obtained a QMCSO, the employee will be required to provide coverage for any child(ren) named in the QMCSO. If a QMCSO requires that the employee provide health coverage for his/her child(ren) and the employee does not enroll them, the employer must enroll the child(ren) upon application from the separated/divorced spouse, the state child support agency or Medicaid agency and withhold from the employee's pay the cost of such coverage. The employee may not drop coverage for the child(ren) unless the employee submits written evidence that the QMCSO is no longer in effect. The Plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren).

2.15 ***USERRA:*** The Uniformed Services Employment and Reemployment Rights Act (USERRA) may entitle qualified employees to continue their coverage. If called to active military service for up to thirty-one (31) days, coverage under this Plan will be continued. If called to active military service for a period exceeding thirty-one (31) days, coverage may be continued for up to twenty-four (24) months. Employees who return to active employment following active duty service as a member of the United States Armed Forces, will be reinstated to coverage under this Plan immediately upon returning from military service. Any questions regarding this should be directed to the employer.

2.16 ***FMLA:*** In accordance with the "Family and Medical Leave Act of 1993" (FMLA), qualified employees are entitled to unpaid leave and can continue to maintain coverage under this Plan for the duration of the leave. During the leave, the employer will continue Plan contributions for the employee on the same terms as prior to the beginning of the leave. The employee is responsible for making the required monthly premium contributions for dependent coverage.

If coverage for dependents is terminated for failure to make payments while the Covered Employee is on an approved family or medical leave, coverage for the eligible dependents can be automatically reinstated on the date the Covered Employee returns to active employment. The returning dependent will be subject to the pre-existing limitation as a "late enrollee". All accumulated annual and lifetime maximums will apply.

2.17 If a Covered Person's eligibility ceases due to certain Qualifying Events, the individual may be eligible for continuation of coverage under COBRA as defined in Article IV.

ARTICLE III

TERMINATION

3.01 Employee coverage under this Plan shall terminate at midnight on the last day of the month following the earliest of :

a] The date of termination of his/her employment;
b] The date the employee ceases to be in a Class of employees eligible for coverage;
c] The due date the employee fails to make any required contributions;
d] The date this Plan is discontinued with respect to the Employer;
e] The date the Fund or Plan terminates.

3.02 A dependent's coverage under this Plan shall terminate at midnight on the earliest of the following dates:
a] The date the employee's coverage terminates;
b] The date ending the period for which the last contribution is made for the dependent coverage;
c] The date of termination of all or any dependent coverage under this Plan;
d] The date on which he/she ceases to be an eligible dependent under this Plan.

3.03 At the sole discretion of, and at the election of the employer, termination of this Plan shall automatically occur upon the first day following thirty (30) days written notice of termination of the Plan.

3.04 In addition to the above stated termination provisions, continued coverage under COBRA ceases for a "Qualified Beneficiary" according to the COBRA termination rules in Article IV.

3.05 Upon termination of coverage, this plan will issue the terminated Plan Member a Certificate of Creditable Coverage that indicates the dates the Plan Member had coverage under this Plan.

ARTICLE IV

CONTINUATION OF COVERAGE (COBRA)

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that employers provide for the temporary continuation of group health coverage to "Qualified Beneficiaries" enrolled in the Plan, whose coverage ends as a result of a specified "Qualifying Event". A Qualified Beneficiary's coverage under COBRA will generally be identical to the coverage that he/she had immediately before the Qualifying Event. Any modification to the Plan that affects active employees will also affect COBRA participants. Qualified Beneficiaries will have the same enrollment and election change rights as active employees. For additional information on COBRA continuation coverage, rights, and obligations, contact your employer or Administrative Enterprises, Inc., the Claims Administrator.

This Article serves as notice to all Plan Members of their rights and obligations under the Federal COBRA continuation of coverage regulations.

4.01 *QUALIFIED BENEFICIARY*

Active employees and their spouses and dependent children become Qualified Beneficiaries if they were covered under this Plan on the day preceding a "Qualifying Event." A child who is born to or who is placed for adoption with a Qualified Beneficiary during a period of COBRA continuation can be enrolled in this Plan for the time frame remaining for any other dependents covered under COBRA.

4.02 *QUALIFYING EVENT*

A Qualifying Event occurs for a Covered Employee and his/her Covered Dependents:

a] If the employee is terminated for any reason other than gross misconduct;
b] If the employee is made ineligible due to a reduction in work hours which puts him/her below the minimum hour requirements stated in the eligibility section of the Plan.

A Qualifying Event also occurs for a Covered Spouse and Covered Dependent Children when it is due to:

a] Death of the Covered Employee;
b] Divorce or legal separation from the Covered Employee;
c] The Covered Employee becomes entitled to Medicare;
d] The Covered Dependent no longer satisfies the Plan's definition of an eligible dependent.

4.03 *NOTIFICATION AND ELECTION*

The employer must notify the employee of the right to continued coverage when the employee is first covered under the Plan (which is included in the new employee information packets), and the information must be included in the Summary Plan Description.

The Covered Employee or Qualified Beneficiary must notify their employer and the Claims Administrator in writing of a marriage, a divorce, a legal separation or the addition of a child, within thirty-one (31) days of the event. The Plan must be notified within sixty (60) days when a child loses their dependent status, or when a Qualified Beneficiary becomes eligible for Medicare. Failure to provide notification within the required time limits will result in loss of COBRA rights. The Employer/Claims Administrator then must notify the appropriate Qualified Beneficiaries of their right to continue coverage within fourteen (14) days. Notice by first-class mail to the beneficiary's last known address satisfies this requirement.

The Covered Employee or Qualified Beneficiary must make the decision to continue coverage and return completed election form within sixty (60) days of the Qualifying Event or within sixty (60) days of the date the notification of COBRA rights was provided, whichever occurs later, or else the individual forfeits their right to COBRA coverage. A parent or legal guardian may elect COBRA coverage for a minor child.

4.04 *DURATION OF COVERAGE*

The maximum period of continued coverage will be as follows (subject to modifications and changes in the Federal COBRA regulations):

a] Employees and Qualified Beneficiaries who lose their coverage due to employment termination (for other than gross misconduct) or reduction of hours worked that makes them ineligible for coverage, are allowed continuation of coverage for a maximum period of eighteen (18) months.

If a Covered Employee or Covered Dependent is entitled to the eighteen (18) months of COBRA, that period can be extended for an additional eleven (11) months if a Qualified Beneficiary is determined to be entitled to Social Security disability benefits. The eleven (11) month extension is available to all the Qualified Beneficiaries in the family who have elected COBRA coverage (not just the disabled person). The following conditions must be satisfied:

1) The disability occurred on or before the start of COBRA continuation coverage, or occurs within the first sixty (60) days of COBRA continuation coverage; and
2) The disabled person receives a determination from Social Security that they are entitled to disability income benefits, and this determination is received before or during the original eighteen (18) month COBRA period; and
3) The disabled person notifies the Plan within sixty (60) days of receiving the determination of disability from Social Security.

This extended period of COBRA continuation coverage will end at the **earlier** of:

1) The end of twenty-nine (29) months from the date of the qualifying event; or
2) The date the disabled person becomes entitled to Medicare; or
3) The date Social Security determines the individual is no longer considered disabled under Title II or XVI of the Social Security Act. Note: The disabled person is required by law to notify the Plan Administrator within thirty (30) days of any change in disability status.

b] Qualified Beneficiaries due to any other Qualifying Event are allowed a continuation of coverage for a maximum period of thirty-six (36) months.

c] If the employee's qualifying event is termination of employment or reduction of hours, and it occurred within eighteen (18) months of becoming entitled to Medicare, the COBRA coverage period for the qualified dependents will be either eighteen (18) months from the termination of employment or thirty-six (36) months from the earlier Medicare entitlement date, whichever is longer. If Medicare entitlement occurred more than eighteen (18) months before termination of employment, this rule does not apply.

d] If an individual was covered under Medicare due to End Stage Renal Disease (ESRD) at the time of the Qualifying Event, the Qualified Beneficiary would be eligible for COBRA for the full time allowed by law, however Medicare would become primary on the thirty-first (31st) month of the Medicare eligibility. If the COBRA participant becomes eligible for Medicare due to ESRD after their COBRA effective date COBRA would terminate on the date Medicare becomes effective.

Second Qualifying Event: If an individual experiences more than one Qualifying Event, the maximum period of coverage will be calculated from the date of the earliest Qualifying Event, but will be extended to the full thirty-six (36) months if required by the subsequent Qualifying Event.

4.05 *COBRA and FMLA*

An FMLA leave does not make a Covered Person eligible for COBRA coverage. Whether or not coverage is lost because of nonpayment of premium during an FMLA leave, the Covered Person may be eligible for COBRA on the last day of the FMLA leave, which is the earliest to occur of:

a] When the employee informs their employer that he/she is not returning at the end of the leave; or
b] At the end of the leave, assuming the employee does not return; or
c] When the FMLA entitlement ends.

For the purpose of an FMLA leave, the employee and his/her covered dependents will be eligible for COBRA as described above only if:

a] The employee and/or his/her dependents were covered under this Plan on the day before the leave commenced (or became covered during the FMLA leave); and
b] The employee does not return to employment at the end of the FMLA leave; and
c] The employee and/or his/her dependents lose coverage under this Plan before the end of what would be the maximum COBRA continuation period.

4.06 *COVERAGE TERMINATION*

Coverage under COBRA will cease on:

a] The last day of the month for which premiums have been paid;
b] The date the Qualified Beneficiary becomes covered under another group health plan (whether as an employee or otherwise) provided that the other group plan does not contain an exclusion or limitation with respect to any pre-existing condition of such individual. In the event a pre-existing condition limitation applies, all Qualified Beneficiaries can remain on this Plan's continuation of coverage;
c] The date the Qualified Beneficiary becomes entitled to Medicare benefits;
d] The last day of the maximum period of continuation the Beneficiary qualified for;
e] The date the employer ceases to maintain any group health plan for any employee;
f] The 30th day following the month in which SSA determines the Qualified Beneficiary is no longer disabled, for those on the extended eleven (11) month continuation of coverage.

Once continuation of coverage begins the employer must be notified in writing if the Qualified Beneficiary is no longer eligible for continuation of coverage or no longer wishes to continue coverage.

4.07 *COST OF COBRA CONTINUATION OF COVERAGE*

The cost of continuation of coverage under COBRA is determined by the Employer and is paid by the Qualified Beneficiary. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the Plan's cost of providing coverage. The cost during a period of extended continuation of coverage due to a disability cannot exceed 150% of the Plan's cost of coverage.

a] The employee or the Qualified Beneficiary must make the initial payment within forty-five (45) days of notifying the Plan Administrator of their election to continue coverage. The initial payment must include all monthly premiums due back to the date regular coverage terminated.
b] Future payments must be made within thirty (30) days of the scheduled due date. The due date for COBRA premiums is the first day of each month.
c] Rates and payment schedules are established by your employer and may change when necessary due to Plan modifications.
d] The cost to continue coverage is computed from the date coverage would have normally ended due to the Qualifying Event.
e] Failure to make the first payment within forty-five (45) days or any subsequent payment within thirty (30) days of the established due date will result in the permanent cancellation of continuation coverage. Coverage will terminate retroactively to the last day of the month for which the last premium was paid.

f] When a premium check is received timely, and that check subsequently is not honored by the bank (i.e.: the check bounces due to insufficient funds), the premium will not be treated as timely paid. The Qualified Beneficiary will be allowed to correct the payment provided it is done within the original thirty (30) day period following the premium due date.

g] Payment of benefit claims filed during the sixty (60) day COBRA election period and the period before receipt of the first COBRA premium payment by an individual eligible to make an election will be denied by the Plan until the individual both timely elects COBRA continuation coverage and pays the first required COBRA premium. Once a timely election is made and required premium payments are received, previously denied claims will be processed as if coverage had not been terminated. These benefit claims will not be paid if timely COBRA continuation coverage election and premium payments are not made.

h] Legislative changes introduced in the American Recovery and Reinvestment Act (ARRA) included a provision to provide reduced COBRA premiums for "Assistance Eligible Individuals". This legislation provides for a sixty-five percent (65%) reduction in premium for a maximum period of nine (9) months for plan members who experience a COBRA-qualifying event between September 01, 2008 and December 31, 2009. To be considered an "Assistance Eligible Individual," plan members are required to meet **all** of the following requirements:

- You must lose coverage under this Plan as a result of an involuntary termination other than gross misconduct; and
- The loss of coverage must occur between September 01, 2008 and December 31, 2009; and
- You must timely elect to continue your benefit through COBRA; and
- The reason your health benefits were terminated must be due to an involuntary termination of employment. An employer-imposed reduction of hours, which prompts a voluntary termination, may be a qualifying event.
- You must not be eligible for Medicare; and
- You must not be eligible for coverage under any other group health plan, such as a health plan sponsored by a new employer or your spouse's health plan.

For further information about ARRA or to determine whether you are an Assistance Eligible Individual, please contact the COBRA Administrator.

ARTICLE V

MAJOR MEDICAL BENEFITS

If, as a result of a covered Injury or Illness, a Covered Person incurs charges for services and supplies described in this Article, the Plan will be payable subject to the Schedule of Benefits. For the purpose of these benefits, for a charge to be considered eligible the charge must be: a) administered or ordered by a Covered Physician; b) medically necessary; c) not of an experimental or investigational nature; d) not of a custodial nature; e) reasonable and customary treatment relative to the diagnosis; and f) a usual and customary amount for the service that is rendered or the item that is purchased as determined by the Plan or its designee.

Any amounts charged that are in excess of what the Plan determines to be the Usual, Reasonable and Customary amount will not be eligible under this Plan.

All Eligible Expenses are subject to the exclusions, limitations and conditions elsewhere stated in this Plan. The Major Medical Benefits payable will be subject to the Schedule of Benefits, are subject to the specified deductible provisions, and shall not exceed the maximums specified. Unless otherwise stated, all benefits are calculated on a per Person per Calendar Year basis.

DEDUCTIBLES / CO-PAYMENTS / CO-INSURANCE

All Eligible Expenses are either subject to a co-pay or the annual deductible as listed on the Schedule of Benefits, and the applicable co-insurance level.

5.01 ***Individual Deductible:*** The individual deductible represents the dollar amount shown in the Schedule of Benefits which must be accumulated in Eligible Expenses by a Covered Person during each Calendar Year, before benefits are payable under this Plan. The Deductible is applied in the order of the Plan's receipt of eligible expenses. The Plan has separate Deductibles for In-Network and Out-of-Network expenses for services performed in 2009.

5.02 ***Family Deductible:*** When the total eligible medical expenses that apply to the satisfaction of the individual deductibles exceeds the family deductible amount shown in the Schedule of Benefits, no further deductibles for any family member will be required for the remainder of the Calendar Year. If both husband and wife are Covered Employees, credit will be given towards the "Family Deductible". One individual cannot satisfy the family deductible.

5.03 ***Carryover Provision:*** Eligible Expenses incurred during the last three (3) months of the Calendar Year which are actually applied toward satisfaction of the deductible may be "carried over" towards satisfying the subsequent Calendar Year's deductible.

5.04 ***Co-payment/Co-pay:*** The co-payment is the dollar amount (as indicated in the Schedule of Benefits) which a Covered Person must pay in conjunction with the receipt of certain eligible services. Co-pay amounts are not applied to deductibles or to the out-of-pocket maximums.

5.05 ***Co-insurance:*** Co-insurance is the percentage of a claim that represents the amount the Covered Person is financially responsible for after the deductible has been satisfied.

5.06 ***Out-of-Pocket Maximum:*** The out-of-pocket maximum is the total dollar amount shown in the Schedule of Benefits that is accumulated per person per Calendar Year in Eligible Expenses and paid at the co-insurance percentage. After the out-of-pocket maximum has been reached, the Plan will pay Eligible Expenses for the remainder of the Calendar Year at one hundred percent (100%). Deductibles, co-payments, Mental/Nervous/Substance Abuse and pre-certification penalties do not apply to the out-of-pocket maximums. The Plan has separate out-of-pocket maximums for 2009 In-Network and Out-of-Network benefits.

FOR THE PURPOSE OF THIS PLAN DOCUMENT ELIGIBLE MEDICAL EXPENSES INCLUDE:

HOSPITAL / FACILITIES

5.07 **Emergency Room**: Charges by the Hospital for the use of the Hospital emergency room for appropriate medical charges necessitated by an acute medical emergency.

5.08 **Hospice**: Charges incurred for hospice care provided by an institution or agency licensed as a Hospice and certified to receive payment under Medicare, when it has been determined that the Covered Person has less than six (6) months to live. The care must be certified by the attending Physician, documenting the necessity of such care when traditional medical treatment and cure-oriented services are no longer medically appropriate due to the Covered Person's terminal condition. The plan of Hospice Care must be renewed in writing by the attending Physician every thirty (30) days. Hospice benefits are limited to sixty (60) days per twelve (12) consecutive months. Hospice care benefits cease if the terminal illness enters remission.

5.09 **Inpatient Hospital**: Charges for semi-private room and board, intensive care and miscellaneous Hospital services directly related to the treatment of the injury or illness that necessitated the confinement. Charges for a private room (that exceed the cost of a semi-private room) are eligible only if prescribed by a Physician and the private room is medically necessary.

5.10 **Licensed Birthing Center**: Charges by a Hospital based or freestanding licensed birthing center.

5.11 **Skilled Nursing Facility**: Charges made by a Skilled Nursing Facility or Extended Care Facility are Eligible Expenses provided the confinement is certified as medically necessary by the attending Physician and the care is not of a custodial nature. Benefits are limited to ninety (90) days per Calendar Year.

5.12 **Surgical Facility**: Charges by a Hospital based or freestanding ambulatory/surgical facility.

5.13 **Urgent Care Facility:** Charges made by an Urgent Care Facility.

SURGERY / ANESTHESIA

5.14 **Anesthesia**: Charges by a licensed anesthesiologist for the administration of anesthetics, pre- and post-operative visits and the administration of fluids and/or blood incidental to the anesthesia or surgical procedure.

5.15 **Assistant Surgeon:** Charges for an assistant surgeon will be considered Eligible Expenses when medically required. If the assistant surgeon is a BlueCross BlueShield of Arizona provider, the eligible charge amount will be up to twenty percent (20%) of the amount allowed for the BCBSAZ surgeon. If the assistant surgeon is a non BCBSAZ Physician, the eligible charge amount will be up to twenty-five (25%) of the amount that would be allowed for a surgeon with the same network status. If the surgical assistant is a non BCBSAZ Registered Nurse First Assistant (RNFA), Certified Surgical Assistant (CSA) or Physician's Assistant (PA), the eligible charge will be up to fifteen percent (15%) of the allowable amount for the surgeon. The services of a standby surgeon will only be covered when: a) a clear medical necessity exists, and b) the standby surgeon is gowned, scrubbed, and physically present in the surgical suite.

5.16 **Organ Transplants:** Charges incurred for non-experimental human to human organ or tissue transplants such as: Heart; Lung; Heart/Lung; Kidney; Pancreas; Liver; Bone Marrow; Cornea, Stem Cell (stem cell transplants for breast cancer are considered experimental/investigational by this Plan).These transplants will only be covered if:

a] The Covered Person is a likely candidate for a successful outcome of the procedure; and
b] The Covered Person properly pre-certifies and maintains case management services throughout the course of the transplantation and post transplantation period as directed and coordinated by the Plan's medical review firm; and

c] The procedure is performed at an In-Network BlueCross of Arizona facility known to have an effective program for doing such procedure. If there is not an In-Network facility that is equipped to perform the transplant, other facilities may be approved provided the facility is approved in advance by the claims administrator and the re-insurance carrier.

Charges associated with the donor for the removal of the organ, and/or the procurement/acquisition/ transportation of the organ will also be considered as Eligible Expenses, subject to the recipient's individual benefit levels and plan maximums. Charges related to the donor for screening and testing are ***not*** covered expenses under this Plan.

5.17 Second Opinions: Second surgical opinions will be covered when required and authorized by the medical review company. The medical review company will direct the Covered Person to a surgeon that is not associated with the original Physician and who specializes in treating the specific surgical problem.

5.18 Surgery: Charges by a Physician for surgery performed at a Hospital, a licensed surgical center or in the office. In the case of multiple surgeries performed through the same incision, the maximum allowable expense shall be equal to the Usual and Customary amount for the procedure with the greatest scheduled amount. Additional allowances (modifiers) may be given when the additional surgeries add significant complexity to the surgical session.

If, during the same surgical session, multiple surgeries are performed through separate incisions, the allowable expense shall be calculated at the full Usual and Customary amount of the primary procedure and at fifty percent (50%) of the Usual and Customary amount of each of the lesser procedure(s) that are through their own separate incision(s).

5.19 Surgery (Oral): Charges for oral surgery for the removal of tumors or cysts, tissue biopsies or for the restoration of sound natural teeth or the alveolar processes due to an accidental injury (restoration made to a functional level). If treatment is delayed, charges will only be eligible if coverage is still in-force at the time the treatment is rendered. Facility charges and charges for general anesthesia related to covered oral surgery will only be eligible if prescribed by a Physician and determined to be necessary for a *medical* reason.

5.20 Surgery (Reconstructive): Charges for reconstructive surgery provided:

a] Reconstructive surgery is required as the direct result of an accidental injury, an infection or disease of the involved part.

b] Reconstructive surgery is necessary for the correction of congenital abnormalities which result in a functional defect.

c] Reconstructive surgery is necessary post mastectomy. Eligible charges will include reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of any physical complications at all stages of mastectomy, including lymphedemas.

MEDICAL / PHYSICIAN SERVICES

5.21 Allergy Testing/Injections: Charges for initial allergy testing, and the cost of the resultant serum preparation and its administration, when rendered by a Physician, or in the Physician's office. Injections of food allergy antigens and the like are ***not*** considered eligible medical expenses. The allowance for antigens will be based on a three (3) month supply and a per vial cost.

5.22 Chemotherapy: Charges for chemotherapy will be considered Eligible Expenses.

5.23 Chiropractic: Charges for spinal manipulations for the correction of structural imbalance, distortion, misalignment or subluxation of or in the vertebral column, by manual or mechanical means, and the necessary adjunctive modalities (hot, cold therapy etc). Charges are limited to forty dollars ($40) payable per visit and twenty (20) visits per Calendar Year.

5.24 Colonoscopy: In addition to the benefits provided for medically necessary colonoscopies, an additional benefit will be provided for a preventative colonoscopy for Covered Persons over the age of fifty (50). One preventative colonoscopy will be covered at 100% once every ten (10) years.

5.25 Dialysis: Charges for dialysis will be considered Eligible Expenses.

5.26 Hearing Examinations and Hearing Aids: One hearing test per Calendar Year will be considered an eligible expense. The charge for one (1) hearing aid will be payable at fifty percent (50%) up to one thousand dollars ($1,000) once every three (3) year period.

5.27 Home Health Care: Charges for home health care/home infusion services rendered by a licensed Home Health Care Agency which a Physician has prescribed and which is determined by the Plan or its designee to be medically necessary and the most appropriate care. Mileage charges may be eligible if the Covered Person resides in a remote area that does not have a local Home Health Care Agency. Charges are subject to an annual maximum of sixty (60) visits. A visit by a representative of a Home Health Agency of four (4) hours or less shall be considered as one (1) Home Health care visit. Charges for custodial care, mental health care, or substance abuse or chemical dependency treatment would not be eligible under this provision.

5.28 Pathology / Radiology: Charges by a laboratory, a pathologist or a radiologist for diagnostic or curative services related to an illness or injury, when ordered by a Physician. Charges for routine screenings are covered under the Routine Physicals/Well Child Care benefit shown in the Schedule of Benefits.

5.29 Physical Therapy / Rehabilitation Services: Charges for rehabilitation services, including physical therapy, physiotherapy, speech therapy and occupational therapy (for short term progressive rehabilitation therapy), provided it is mandated by the disability and is not of a maintenance nature. The rehabilitation therapy must be ordered by and under the supervision of a Doctor of Medicine, Doctor of Osteopathy, or by a Doctor of Podiatry for the area of the body that is within the scope of his/her license, and rendered by a Physician or a Licensed/Registered Therapist. If, at any time, treatment becomes of a maintenance or custodial nature, benefits will cease.

Outpatient rehabilitation treatment is limited to fifteen hundred dollars ($1,500) per condition. Inpatient rehabilitation is limited to a maximum of sixty (60) days and forty thousand dollars ($40,000) per condition. If the condition mandates outpatient or inpatient treatment that exceeds these limitations, the proposed additional treatment must be reviewed and approved in advance by the medical review firm in order for it to be considered for possible additional coverage under this Plan.

5.30 Physician: Charges by a Physician for medical care in the Hospital, emergency room, office, clinic or other health care facility. The services of a Physician's Assistant (PA) or of a Nurse Practitioner will be eligible provided they are operating under the direct supervision of a Physician.

5.31 Radiation Therapy: Charges for radiation therapy are considered an Eligible Expense.

5.32 Speech Therapy: Charges made by a qualified speech therapist for restoration of normal speech or to correct dysphasgic or swallowing disorders, when the loss or impairment is due to a physical injury, illness or surgery, up to twenty (20) visits per Calendar Year. The therapy must be prescribed by a qualified Physician. Speech therapy is ***not*** covered for the correction of stuttering, stammering, myofunctional or conditions of psychoneurotic origin.

5.33 Urgent Care: Services rendered at an urgent care facility when immediate medical attention is necessary.

5.34 Vision Exams: Charges for one routine vision exam per Calendar Year will be covered.

5.35 Wellness/Routine Physical/Well Child Care: Charges for routine wellness care such as routine physicals, routine gynecological examinations, routine laboratory tests and x-rays, routine mammograms, cancer screenings, body scans, bone density scans, and flu shots. Benefits payable are subject to the annual maximum stated in the Schedule of Benefits.

MATERNITY / FAMILY PLANNING

5.36 **Abortions**: Charges incurred for a *medically required* abortion for a Covered Employee or Covered Dependent Spouse when the continuation of the pregnancy would be life threatening to the mother. Expenses related to complications of an abortion (including non-covered abortions) will be considered eligible.

5.37 **Contraception**: Charges for contraceptive devices that require a prescription, insertion and removal of I.U.D.s, the cost for a diaphragm and its' fitting, and medication (birth control pills, Depo-Provera shots, Norplant) for birth control purposes.

5.38 **Midwife**: Charges made by a Certified Nurse Midwife (CNM) for obstetrical or well woman care that is within the scope of his/her license in the state in which he/she is licensed. Charges for well woman care are covered under the Routine Physicals/Well Child Care benefit shown on the Schedule of Benefits.

5.39 **Newborns**: Charges incurred at a Hospital for "routine" newborn care (DRG 795), including charges for a routine in-hospital exam by a pediatrician and routine circumcisions will be covered as part of the mother's maternity claim. Any charges incurred by the newborn for other than routine care or for any routine care after discharge will only be covered if dependent coverage is in effect or is added within thirty-one (31) days of the date of birth. These charges are subject to the newborn's own maximums and deductibles.

5.40 **Pregnancy**: Charges incurred as a result of pregnancy for pre- and post-natal care and delivery for a Covered Employee or Covered Dependent Spouse, provided coverage is in effect at the time the actual charges are incurred (i.e. at the time of delivery). Eligible Expenses include routine lab work, and one (1) routine ultrasound during the course of pregnancy.

5.41 **Sterilizations**: Charges incurred for elective or medically required sterilizations. When a vasectomy is elected, only the Physician's charge for the surgery will be covered. Facility charges for vasectomies are not eligible.

AMBULANCE

5.42 Charges by a licensed professional Ambulance service as follows:

a] Ground ambulance to the nearest appropriate Hospital within twenty-four (24) hours of an Accident or the sudden onset of severe symptoms of an Illness;

b] Transfer by ground ambulance to the nearest Hospital with the necessary equipment, staff and facilities to treat the patient's condition, if treatment cannot be performed at the initial Hospital;

c] Ground ambulance service from the Hospital to the Covered Person's permanent place of residence will be covered, if Medically Necessary, as determined by the Plan or its designee;

d] Transport by air ambulance will be an Eligible Expense as described in a & b above but ***only*** when Medically Necessary due to a life threatening condition.

MEDICATIONS / EQUIPMENT / SUPPLIES

5.43 **Blood:** Blood Transfusion services, including the cost of blood and blood products, to the extent they are not replaced or donated through the operation of a blood bank or otherwise.

5.44 **Bras:** Charges for prosthesis bras (up to 2 per year) and the related post mastectomy prosthetic devices.

5.45 **Contact Lenses**: Charges made for the initial pair of Contact Lenses as prescribed by a Physician when required immediately following cataract surgery.

5.46 **Corrective Appliances / Prosthetics**: Charges for corrective appliances including the original fitting are eligible when ordered by a Physician and necessary due to an Illness or Injury. Charges will only be allowed for the standard model of the Corrective Appliance. The rental or purchase of a Corrective Appliance is at the option of the Plan; rental is payable only up to the allowed purchase price. Charges will be allowed for replacement,

adjustment and servicing of the appliance/prosthesis when necessary due to the growth of a covered child, or when the appliance has exceeded its maximum life expectancy.

5.47 Durable Medical Equipment: Charges for necessary Durable Medical Equipment (DME) as prescribed by a Physician up to a maximum of one thousand dollars ($1,000) per item. Charges will only be allowed for the standard model of the particular piece of equipment. The rental or purchase of DME is at the option of the Plan, and rental is only payable up to the allowed purchase price. DME charges in excess of the $1,000 maximum may be considered eligible, however the item must be reviewed by the Claims Administrator and a determination made ***prior*** to the purchase or rental.

5.48 Medications: Charges for Covered Prescription Drugs and medicines, obtainable only upon a Physician's written prescription, and prescribed for treatment of a covered Illness or Injury. Most prescriptions are purchased with the Rx card issued by the Plan. Covered Persons present their Rx card to the Pharmacist and pay the co-pay amount indicated in the Schedule of Benefits. Medications that can be purchased over-the-counter are ***not*** eligible (including those that can be purchased at a lesser strength).

5.49 Oxygen: Charges for oxygen (when prescribed by a Physician) and for the rental or purchase of the equipment to use it, (equipment charges are subject to the DME rules/limitations in Section 5.47 above).

5.50 Supplies: Charges for the following Non-durable (disposable) supplies are eligible: a) sterile surgical supplies required following a covered Surgery; b) supplies required to operate/use durable medical equipment or corrective appliances; c) supplies required for use by skilled home health or home infusion personnel, only for the duration of their services; d) anti-embolism garments (e.g., Jobst) up to three (3) per calendar year; e) ostomy supplies; f) cervical collars; g) orthopedic braces.

5.51 Orthopedic Shoes / Orthotics: Charges for medically necessary orthopedic shoes and other related supportive appliances, including their replacement once in each twelve (12) month period, or, if under nineteen (19) years of age, once in each six (6) month period if necessitated by the child's growth. Orthotics will only be covered when ordered by a M.D. or D.P.M. and dispensed by a certified orthotics laboratory.

5.52 Wigs: Charges for wigs will be covered for post chemo-therapy patients, up to a maximum payable of three hundred dollars ($300) per Calendar Year.

MENTAL HEALTH CARE / SUBSTANCE ABUSE

5.53 Charges for Mental Health care and treatment, including charges for Attention Deficit Disorder ADD), Attention Deficit Hyperactivity Disorder (ADHD), substance abuse, and chemical dependency are considered Eligible Expenses.

Facility charges for inpatient or residential treatment of mental and nervous disorders, chemical dependency or substance abuse will be eligible when care is received at a licensed Hospital or a licensed treatment facility. Inpatient or residential coverage is limited to thirty (30) days per Calendar Year, two (2) confinements per lifetime. Alternative outpatient facility/day programs/intensive outpatient programs may be eligible under the inpatient benefit when provided in lieu of inpatient care and approved by the medical review company.

Outpatient treatment for mental health care, treatment of chemical dependency or substance abuse, or family counseling will be eligible when rendered by a licensed Psychiatrist, a licensed Psychologist, a Licensed Professional Counselor (LPC), a Licensed Clinical Social Worker (LCSW), a Licensed Independent Substance Abuse Counselor (LISAC), or when rendered by one of the following counselors, provided the counselor is employed by and working under the direct supervision of a Psychiatrist or Clinical Psychologist:

a] Master Social Worker (MSW)
b] Master Science Nurse (MSN)
c] Master of Arts in Guidance & Counseling (MA)
d] Master of Education in Guidance & Counseling (MED)
e] Master in Counseling (MA)

Psychological testing and neuropsychological testing are covered only if it is mandated by the condition and is pre-certified by the medical review company. If approved, testing is paid at fifty percent (50%).

Out-of-pocket expenses related to mental health/chemical dependency/substance abuse do not count towards the Covered Person's out-of-pocket limit. Co-insurance limits do not apply to this provision and therefore benefit percentages would never increase.

ARTICLE VI

PRE-EXISTING CONDITIONS

A pre-existing condition is any medical condition for which the Covered Person received treatment including, but not limited to, diagnosis, consultation, treatment or taking prescribed drugs/medication (including self-administered drugs or biologicals not requiring a Physician's prescription) for an illness or injury, during the six (6) month period immediately preceding the Covered Person's enrollment date of coverage under this Plan.

This pre-existing limitation does not apply to newborns, newly adopted children or pregnancy.

6.01 For new employees and their covered dependents, charges incurred after their enrollment date which are related to a pre-existing condition will not be eligible for benefits until twelve (12) consecutive months from the Covered Person's enrollment date.

6.02 Employees and their dependents who enroll in this Plan more than thirty-one (31) days after their original eligibility date are considered "Late Enrollees". Late Enrollees will not be eligible for benefits related to a pre-existing condition until they have been continuously covered by this Plan for eighteen (18) months. Dental Benefits are not subject to "Late Enrollee" limitations.

6.03 When an employee and his/her dependents enroll in this Plan, and they have previously had "creditable coverage" issued by an eligible health plan or a self-insured group health plan, the time covered under the prior plan will be credited towards the pre-existing waiting period under this Plan. The Covered Person must have been continuously covered under the prior plan, with no more than a sixty-three (63) day gap between coverage under the prior plan and their enrollment date under this Plan.

6.04 "Creditable coverage" is defined in the "Health Insurance Portability and Accountability Act of 1996". Creditable Coverage refers to coverage under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicare (other than coverage solely under Section 1928), Medicaid, military-sponsored health care, a program of the Indian Health Services, a State health benefits risk pool, the Federal Employees Health Benefit Program, a public health plan as defined in regulation, and any health benefit plan of the Peace Corps Act.

6.05 Covered Persons must submit a written "Certificate of Coverage" from their prior insurance carrier as proof of prior creditable/accountable coverage to the Claims Administrator.

ARTICLE VII

GENERAL LIMITATIONS AND EXCLUSIONS

Benefits are not payable under this Plan for any charges or treatment related to, or in connection with the following services and/or conditions, regardless of Medical Necessity or recommendation by a Physician.

7.01 Services and supplies which are not Medically Necessary, as determined by the Plan or its designee, or are not necessitated as the result of existing symptoms of an Illness or Injury, or are not considered the standard medical treatment for the diagnosed condition, except as covered under Article V, Section 5.35.

7.02 Charges for any Illness or Injury incurred prior to a Covered Person's eligibility date as defined in Article II, or after the Covered Person's termination date as defined in Article III.

7.03 Medical care, services or supplies which do not come within the definition of Eligible Expenses and/or are not rendered by an eligible provider of service as defined by this Plan.

7.04 Expenses associated with complications of a noncovered condition, illness, procedure or service.

7.05 Any charges in excess of rates negotiated between any organization and the Physician, Hospital or other provider of services, whether the plan is a Primary or Secondary payer.

7.06 Charges in excess of the Usual, Reasonable and Customary charge for services and supplies, or charges which exceed any Plan benefit limitation or maximum allowable benefit.

7.07 Any services for which a charge would not have been made in the absence of this coverage; or portion of a charge that is higher than the amount that would have been charged in absence of this coverage.

7.08 Charges, or a portion of a charge, for services or supplies that are discounted or reimbursed by a refund or rebate.

7.09 Charges for an Illness or Injury deemed to have arisen out of or in the course of doing any work for wage or profit, whether or not such claim has been reported in accordance with the Workers' Compensation rules. No work related claim shall be payable under this Plan unless the injury or illness has been adjudged as non-occupational by the appropriate Worker's Compensation Board.

7.10 Treatment received, including the use of ambulance service as described in Article V, Section 5.42, for an injury or illness sustained while incarcerated or sustained during the commission of, or the attempted commission of, an assault, a felony or other criminal act whether or not there is a criminal charge or a conviction of a crime, if the offense is defined as a criminal act by the state in which the incident occurred, including injuries received while operating a motor vehicle in an illegal manner, driving while under the influence of alcohol or illegal drugs, negligent driving or driving at excessive speeds.

7.11 Services received or supplies and medication purchased outside the United States unless the charges incurred are a result of a life threatening emergency or accidental injury that occurs while traveling outside the United States.

7.12 Charges incurred for preparing medical reports, itemized bills, or claim forms. Expenses for broken appointments, telephone calls, photocopying fees, mailing, shipping or handling expenses.

7.13 Charges incurred due to a court ordered treatment or hospitalization unless a clear Medical Necessity also exists.

7.14 Services rendered by an immediate family member, whether relationship is by blood or law, or by any person who regularly resides in the Covered Person's home.

7.15 Examinations, vaccinations, inoculations or immunizations related to employment, premarital or pre-adoptive requirements, issuance of insurance, obtaining a license, judicial or administrative procedures, medical research or travel to foreign countries.

7.16 Examinations or tests not incidental to or necessary to diagnose an Injury or Illness except the coverage for the routine care specifically allowed in Article V, Section 5.35.

7.17 Charges or treatment provided as a benefit under a program of the United States Government or State agency or political subdivision, including but not limited to active duty in the armed forces, Medicare, Medicaid, TriCare or any treatment paid for by any governmental program unless the Covered Person is legally required to pay.

7.18 Services received in a U.S. Department of Veterans Affairs (VA) Hospital or VA facility on account of a military service-related illness or injury are not payable by this Plan.

7.19 Treatment of an Illness or Injury resulting from an act of war (whether declared or undeclared), invasion or aggression, or any atomic explosion or release of nuclear energy (except when used solely for the purpose of medical treatment).

7.20 Treatment of an Illness or Injury caused by participating in a civil insurrection or a riot.

ADDITIONAL EXCLUSIONS

The following excluded charges have been arranged in alphabetical order to assist in finding the information. The entire list should be reviewed as the wording of a particular excluded service may place it in a location other than where one might expect to find it.

7.21 Abortions / Elective termination of pregnancy, unless the mother's life would be endangered if the pregnancy were allowed to continue.

7.22 Acupuncture or Acupressure.

7.23 Adoption charges and/or charges incurred by a surrogate mother.

7.24 Assistant surgeon when the need for an assistant is not documented.

7.25 Assistive / Self-help devices which do not serve a primary medical purpose and instead ease the performance of activities of daily living, including but not limited to feeding utensils, reaching tools, devices to assist with dressing and undressing, etc.

7.26 Autologous blood donations are not covered unless the blood is actually used during a scheduled surgery.

7.27 Autopsies (unless required by the Plan).

7.28 Biofeedback, hypnosis, or behavior modification therapy (i.e. stress management, weight reduction, nutrition classes, etc.).

7.29 Breast reconstruction (except as covered under Article V, Section 5.20), or charges for breast augmentation, breast reduction, or prophylactic breast removal. Charges related to the removal of breast implants inserted for cosmetic purposes are not eligible regardless of the reason for removal.

7.30 Chelation therapy, except when necessary for treatment of heavy metal poisoning.

7.31 Cochlear implants or any implant to improve hearing.

7.32 Cosmetic: Charges incurred for services, supplies or surgery which are primarily for personal comfort or primarily to improve or enhance personal appearance, including but not limited to, collagen injections, botox injections, sclerotherapy, liposuction, tattoos or tattoo removal.

7.33 Cosmetic Surgery, plastic surgery, or reconstructive surgery or any complications thereof, except as covered under Article V, Section 5.20.

7.34 Counseling charges incurred for career, sexual, social adjustment, financial or religious reasons.

7.35 Custodial Care: Charges made by an institution or part thereof which is primarily a place for rest, the aged, a hotel, health spa, fitness or weight reduction resort or similar institution or childcare, homemaker services or maintenance care.

7.36 Dental procedures or dental treatment, except as covered under Article V, section 5.19.

7.37 Disposable (non-durable) supplies, including but not limited to diapers, incontinence pads and bandages, except as covered under Article V, Section 5.50.

7.38 Education expenses for job training.

7.39 Elevators, chairlifts or other modifications to home, stairs or vehicles.

7.40 Exercise: Charges incurred or related to health club/exercise/gym memberships, aerobic and strength conditioning, back schools or back strengthening programs, massage therapy, rolfing, and exercise equipment rental or purchase, health spas, or fitness resorts or similar institutions.

7.41 Experimental / Investigational: Charges for services, procedures, equipment or supplies which are considered experimental or investigational as defined in Article XI, Section 11.32.

7.42 Eye surgery (Kerato-refractive surgery) to correct nearsightedness or farsightedness and/or astigmatism, including but not limited to Radial Keratotomy, keratomileusis surgery, refractive keratoplasties, and LASIK surgery.

7.43 Genetic testing/screenings due to family history or genetic services rendered during pregnancy (or in anticipation of a pregnancy), including tests and procedures performed for the purpose of detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics, except alphafetoprotein analysis.

7.44 Hair Loss: Charges for hair transplants, wigs, toupees, hair weaving, or services/supplies for the prevention or restoration of natural hair loss (i.e. Rogaine, Minoxidil, Propecia etc.), except as covered under Article V, Section 5.52.

7.45 Health Maintenance Organization (HMO) providers when services are rendered to a covered HMO plan member.

7.46 Hearing related surgery or supplies related to hearing implants.

7.47 Holistic services, supplies or accommodations provided in connection with holistic or homeopathic treatment or medicine.

7.48 Infertility: Charges related to the treatment of infertility, infertility drugs or ultra sounds associated with infertility medication therapy, collection of semen and/or ovum, artificial insemination, In-Vitro fertilization, Gamete Intro Fallopian Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), embryonic transfer, sperm donor costs, sperm banking and/or storage, sperm washing or any other similar procedure. (charges to diagnose the condition of infertility will be considered Eligible Expenses).

7.49 Learning Disabilities: Charges (including mental health care) related to treatment or testing of learning disabilities, developmental disorders, dyslexia, autism or mental retardation or any similar conditions. Medications and office visits to monitor medications for these conditions will be eligible.

7.50 Maternity care for dependent daughters, or any complications thereof, or any charges incurred by the newborn.

7.51 Magnet therapy.

7.52 Massage therapy or rolfing unless it is performed in conjunction with physical therapy and is performed by an eligible practitioner.

7.53 Maintenance rehabilitation therapy or therapy for coma stimulation, either Inpatient or Outpatient.

7.54 Medical students, interns or residents.

7.55 Medications: Charges for experimental or non-prescription medications, charges for prescriptions to be used for an application that has not been approved by the FDA or medications that can be purchased over-the-counter. Non-smoking aids, drugs for cosmetic purposes, weight control drugs or fertility agents. All eligible prescriptions are provided through the prescription drug card.

7.56 Music therapy.

7.57 Myofunctional therapy or the treatment of tongue thrusts.

7.58 Naturopathic treatment or services rendered by a Naturopath.

7.59 Nutritional counseling or classes.

7.60 Occupational therapy and supplies, except during an Inpatient Hospital confinement or except as covered under Article V, Sections 5.27 and 5.29.

7.61 Organ or tissue transplants (except as covered under Article V, Section 5.16), including insertion or maintenance of an artificial heart or organ and charges for artificial, experimental or non-human body organs or tissue transplants.

7.62 Orthognathic surgery.

7.63 Orthotics, except as covered under Article V, Section 5.51.

7.64 Pediatrician charges for services as a standby pediatrician during childbirth unless a high risk factor was indicated during the covered pregnancy.

7.65 Personal comfort items or devices which do not meet the definition of Durable Medical Equipment or Corrective Appliances including but not limited to air conditioners, air purifiers, dehumidifiers, water purification systems, waterbeds, airbed systems, cervical pillows, whirlpools, spas and the like.

7.66 Personal service items while confined in a Hospital or health care facility (i.e. guest meals, television, telephone, etc.).

7.67 Private duty nursing services while Hospital confined.

7.68 Prosthesis replacement unless necessitated by the growth of a child or the prosthesis has exceeded its maximum life expectancy.

7.69 Reversal surgery of any kind.

7.70 Sexual dysfunction or sexual inadequacy, including but not limited to sex change operations, medications, penile prosthetic implants or similar devices.

7.71 Sleep Disorders: Charges related to the diagnosis and treatment of sleep disorders, except in the case of sleep apnea.

7.72 Smoking cessation programs, aids, devices or drugs (i.e. Nicorette and Nicoderm).

7.73 Special Education: Charges made by a special education facility, tutor, behavior specialist or provider of any kind for testing or treatment of learning disabilities, developmental disorders or attention deficit disorders (ADD and ADHD).

7.74 Surrogate Mothers: Any and all costs for and relating to surrogate motherhood, or charges incurred by a Covered Person acting as a surrogate mother.

7.75 TMJ: Charges for surgical or non-surgical care or treatment related to Temporomandibular Joint Dysfunction or Syndrome (TMJ), craniomandibular disorders, reconstruction of the maxilla or mandible for micrognathism, or retrognathism or orthognathic surgery.

7.76 Transportation charges except for ambulance provided in Article V, Section 5.42.

7.77 Travel charges (transportation, lodging, meals and related expenses) by a Covered Person, a Physician or any healthcare provider except as provided in Article V, Section 5.27.

7.78 Vision: Charges incurred for diagnosis or treatment relating to eye refractive error, orthoptic or visual training, vision therapy, testing for visual acuity, field charting or for eyeglasses or contact lenses or for the fitting of such items, except as covered under Article V, Section 5.34 and 5.45.

7.79 Vitamins, nutritional supplements, minerals, diets, foods, infant formula and naturopathic or homeopathic services and/or substances whether prescribed by a Physician or purchased over-the-counter.

7.80 Virtual office visits, phone or internet consultations.

7.81 Vocational or educational training services, supplies or materials.

7.82 Weight Loss/Obesity: Expenses for care, treatment, supplies, instruction or activities for weight reduction, weight control, weight loss programs, or physical fitness, even if such services are performed or prescribed by a physician; weight control drugs, supplies, supplements or substances; or surgery, including any type or variation of bariatric surgery.

Bariatric surgery may be considered eligible if the Covered Person meets all of the following criteria and the procedure is performed by In-Network providers (surgeons, assistant surgeons, anethesiologists etc.) at an In-Network facility known to have an effective program for doing such a surgery and a follow-up program:

a] The person has been covered under the this Plan for a minimum of 24 months immediately preceding the date of the procedure; and

b] The Covered Person is at least eighteen (18) years of age, is physically mature, is not older than sixty (65) years of age; and

c] Two separate physicians confirm in writing that the Covered Person:
   1. Is, and has been for two (2) or more years prior to the procedure, Morbidly Obese; and
   2. Is an acceptable surgical interventional risk (i.e. he/she must otherwise be a good surgical candidate); and
   3. Does not have a specifically correctable cause of obesity, such as a glandular or endocrine problem;

d] The Covered Person provides evidence of physician documented compliance with a structured, medically guided weight reduction program for at least six (6) months prior to the proposed surgery and the Covered Person has failed to maintain weight loss; and

e] A licensed psychologist or psychiatrist, a dietitian, an exercise physiologist and a surgeon have confirmed in writing that the Covered Person has met with them and the Covered Person is both physically and mentally prepared to undergo the proposed bariatric surgery and a structured post-operative exercise, diet and related follow-up program; and

f] The Covered Person provides written documentation from a licensed psychologist or psychiatrist confirming the absence of a significant psychopathology that may limit the Covered Person's understanding of the procedure, ability to comply with medical/surgical recommendations and post-surgery lifestyle changes necessary for the procedure to be successful.

Benefits will not be provided for subsequent procedures to correct further injury or illness resulting from the Covered Person's non-compliance with prescribed medical treatment follow-up post-surgery. Expenses which are medically necessary, in connection with services or supplies and surgical procedures performed in connection with Morbid Obesity, will receive benefits as described in the schedule of benefits.

The term "Morbid Obesity," for purposes of this exclusion and this Plan, means the Covered Person meets one or more of the following:

a] A diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person;

b] The Covered Person has a Body Mass Index (BMI) of forty (40) or more;

c] The Covered Person has a Body Mass Index (BMI) of thirty-five (35) or more and the Covered Person also, at the same time, suffers from two or more co-morbid medical conditions such as life-threatening pulmonary problems, severe diabetes, or severe joint disease surgically treatable except for the obesity, but such conditions may be improved by the performance of the bariatric surgery.

The benefits payable for bariatric surgery, gastric bypass, or any other type of surgical weight loss procedure are limited that such a Covered Person is only eligible for such benefits one (1) time during the life of the Covered Person.

ARTICLE VIII

DENTAL BENEFITS

The Dental Benefits are payable in accordance with the Dental Benefits schedule in Article I, and are subject to the Dental Deductible, Dental Limitations and Exclusions, Dental Maximums herein and all other Plan provisions.

If a Covered Person incurs eligible dental expenses, the Plan will pay the Usual, Reasonable and Customary eligible charge at the percentage indicated in the Schedule of Dental Benefits. The Plan provides benefits only for the most cost effective treatment that provides a satisfactory, functional result as determined by the Claims Administrator or its designee.

8.01 *DENTAL DEDUCTIBLE*

The Dental Deductible is the amount of eligible Dental charges which must be incurred by each Covered Person each Calendar Year before benefits are payable. The family deductible amount applies collectively to all Covered Persons in the same family aggregate. When the family deductible is satisfied no further deductible will be applied for the remainder of the Calendar Year. The Dental Deductible does not apply to covered Diagnostic, Preventive or Orthodontic Services.

8.02 *DENTAL MAXIMUM*

The Calendar Year dental maximum stated in Article I, Section 1.09 is the total of benefits payable per person, per Calendar Year for all dental services combined (excluding orthodontia). Article I, Section 1.09 also states a lifetime maximum for eligible orthodontia.

8.03 *DENTAL SERVICES INCURRED DATE*

An eligible dental charge is considered incurred as follows:

a] A charge is incurred at the time the impression is made for an appliance or modification of an appliance.
b] A charge is incurred at the time the tooth or teeth are prepared for a crown, bridge or gold restoration.
c] A charge is incurred at the time the pulp chamber is opened for root canal therapy.
d] Orthodontic care - the date the active course of treatment begins.
e] All other charges are incurred at the time the dental service is rendered or the supply furnished.

COVERED DENTAL SERVICES

8.04 Diagnostic and Preventive Service means the procedures necessary to evaluate the conditions existing and the procedures or techniques to prevent the occurrence of dental abnormalities or disease. Diagnostic services provide for the necessary examination and x-ray procedures to assist the Dentist in evaluating the conditions existing and the dental care required. Preventive services provide for procedures necessary to clean, scale and polish teeth and apply fluoride.

a] Routine Oral Examinations.
b] Prophylaxis / Cleanings (Periodontic cleanings can be substituted at the U&C rate payable for a routine cleaning).
c] Topical fluoride treatments.
d] Full mouth and bitewing x-rays.
e] Emergency palliative treatment to relieve pain when no other dental treatment is given. (If additional treatment, other than x-rays, is given the amount of benefits paid for the pain relief will be based on the category of that treatment.)
f] Space Maintainers that replace prematurely lost primary teeth for children under age fourteen (14).

Diagnostic and Preventive Services - Limitations

a] Routine oral examinations and cleanings limited to two (2) per Calendar Year.
b] Bitewing x-rays limited to one (1) set per Calendar Year.
c] One set of full mouth or panorex x-rays within a thirty-six (36) month period.
d] Topical fluoride treatments are limited to children under age seventeen (17) and limited to two (2) per Calendar Year.

8.05 Restorative Service means the necessary procedures to restore teeth to normal contour and function.

a] Fillings: amalgam, synthetic, porcelain, plastic or composite materials.
b] Simple Extractions.
c] Sealants.

Restorative Services – Limitations

a] Sealants are limited to children up to age nineteen (19) and are limited to once per three (3) year period for permanent molars and bicuspids.

8.06 Endodontic Service means the necessary examinations and procedures for diagnosis and treatment of diseases of the tooth pulp and/or infections of the root canal and periapical area.

a] Pulp therapy and root canal treatment.

8.07 Periodontic Service means the necessary examination and procedures for diagnosis and treatment of the periodontium. The periodontium is collectively the tissue that surround and support the teeth (including the gingiva, cementum, periodontal membrane, and the supporting alveolar bone).

a] Treatment for disease of gingival tissue or alveolar supporting structures of the mouth, including periodontal surgery.
b] Occlusal adjustments, only in connection with periodontal treatment.
c] Full mouth debridement, once per twelve (12) month period.

Periodontic Services: Limitations / Exclusions

a] Surgical periodontal treatment is limited to once in a thirty-six (36) month period for each quadrant.
b] Crown lengthening or single tooth gingivectomy are allowed once in conjunction with crown preparation.
c] Periodontal Prophys are limited to once every six (6) months, not to exceed two (2) per Calendar Year.
d] Non-surgical periodontal treatment is limited to once per quadrant every twenty-four (24) months.

8.08 Oral Surgery means the necessary examination and procedures for treatment by extraction or other oral surgery not covered under periodontic services.

a] Provides the necessary procedures for complex extractions and other oral surgical procedures including removal of impacted teeth, including pre- and postoperative care.
b] Anesthesia in conjunction with a covered oral surgery procedure (not allowed for simple extractions).

8.09 Prosthodontic Service means the necessary procedures or techniques concerned with the restoration and replacement of teeth. Dental prostheses may be either fixed or removable.

a] Porcelain, composite, or gold inlays and onlays.
b] Crowns: three-quarter, full and stainless steel.
c] Charges for fixed bridges, Maryland bridges, and full and partial Dentures.
d] Charges for adjusting, relining, re-basing or repairing bridges or dentures and re-cementing inlays, onlays, crowns, or bridges.

Initial placement of bridges, or full or partial dentures (charges will be considered "initial placement" only if they are not replacing an existing bridge or denture) are Eligible Expenses provided:

a] Placement is due to the extraction of one or more natural, injured or diseased teeth; and
b] Placement of bridge or denture includes replacement of extracted tooth.

Replacement of an existing fixed bridge or a full or partial denture are Eligible Expenses provided:

a] Prosthetic appliance to be replaced was placed more than five (5) years ago and cannot be made satisfactory; or
b] Addition of teeth is needed to replace one (1) or more natural teeth extracted; or
c] Replacement of existing fixed bridge or denture is due to an accidental injury requiring oral surgery.

Prosthodontic Services – Limitations / Exclusions

a] Temporary partial dentures are allowed only when anterior teeth are missing.
b] Charges for replacement due to loss or theft of denture or fixed bridge is ***not*** covered.
c] Implants are payable up to the amount that would have been allowed for a comparable bridge (fixed partial denture).
d] Temporary full dentures are not covered.
e] Anterior space maintainers are not covered.
f] Replacement of an existing bridge or denture that can be made satisfactory is not covered.

8.10 Orthodontic Service means the detection and active treatment and appliance for the correction of abnormalities of the teeth and malocclusion. Orthodontic services are only payable for Covered Persons banded by the age of seventeen (17), and are subject to a separate orthodontic lifetime maximum.

a] Active course of treatment shall mean any services for diagnostic casts, x-rays, records, tooth extraction or the placement of active orthodontic appliances. The active course of orthodontic treatment is the period which begins when the first orthodontic service is performed and ends when the last active appliance is removed.
b] The initial banding will represent twenty-five percent (25%) of the allowable charge for the complete orthodontic treatment plan. Payments for the subsequent active orthodontic treatment will be processed on a monthly basis with the balance prorated over the total period of the orthodontic treatment plan.
c] The orthodontic benefit maximum for a Covered Person for any one course of treatment will include the charges incurred for diagnosis, evaluation pre-care and x-rays.

Orthodontic Services – Limitations / Exclusions

a] Orthodontic treatment which commenced before the date the Covered Person became eligible under this Dental Plan will not be covered.
b] Orthodontic treatment that will occasion major restorative dental work not ordinarily performed in general dentistry.
c] Orthodontic treatment for cases in which the desired results are unlikely to be obtained, such as those with severe periodontal problems, poor bone structure or extremely short roots.
d] Orthodontic treatment for patients with severe medical disabilities which may prevent satisfactory orthodontic results.
e] Orthodontic treatment plans, which, in the opinion of the Plan, are unlikely to produce professionally accepted corrections of existing malocclusion.
f] Charges for or related to Invisalign are not covered.

GENERAL DENTAL LIMITATIONS AND EXCLUSIONS

8.11 In addition to the Limitations/Exclusions previously listed in this Article and the Pre-Existing Conditions Limitation in Article VI, the Plan does not cover Dental Expenses for the following:

1. **Analgesia,** sedation or hypnosis for relief of anxiety or apprehension.
2. **Anesthesia** unless administered in conjunction with covered oral surgery (not covered for simple extractions).
3. **Appliances** to increase vertical dimension or to restore or alter occlusion for cosmetic or non-cosmetic purposes, except as covered under orthodontia.
4. **Assignment** of dental benefits to a provider outside of the United States.
5. **Charges** in excess of the Usual and Customary charge.
6. **Charges** incurred for any procedure which commenced **before** the Covered Person's effective date under this Plan, or any supplies furnished in connection with such procedure, except that for the purpose of this Dental Limitation, x-rays or prophylaxis treatment shall not be deemed to commence a dental procedure.
7. **Complications** resulting from a non-covered service.
8. **Congenital** or developmental malformations.
9. **Cosmetic** dental procedures performed for reasons including, but not limited to, bleaching, whitening, altering or extracting and replacing sound natural teeth to change appearance.
10. **Dental procedures** covered under the medical expense provisions of this Plan.
11. **Dental services** not rendered by a dentist (D.D.S. or D.M.D.) or by a dental hygienist or x-ray technician under the supervision of a dentist, except in emergency situations when charges by an M.D. or D.O. would be considered eligible.
12. **Duplicate** or spare prosthetic devices or appliances.
13. **Extra oral grafts** (grafting of tissue from outside the mouth to oral tissues).
14. **Hospital** or surgical facility charges incurred for dental services.
15 **Myofunctional** therapy.
16. **Nightguards**, athletic mouthguards, splints, or harmful habit appliances.
17. **Oral hygiene** instructions or supplies, dietary or plaque programs, or other educational programs.
18. **Orthognathic** or **TMJ** treatment or surgery.
19. **Precision attachments,** semi-precision attachments or Stress-breakers.
20. **Preparation of dental reports**, itemized bills or claim forms, or charges for broken appointments, telephone calls, photocopying fees, or mailing.
21. **Prescription drugs**, unless available through the RX card.
22 **Replacement** of lost or stolen appliances (i.e. denture, bridges, orthodontic appliances etc.).
23. **Services or supplies** not recognized or recommended by the American Dental Association.
24. **Veneers.**

ARTICLE IX

SHORT TERM DISABILITY BENEFIT
COUNTY EMPLOYEES ONLY

If a Covered County Employee becomes disabled and is unable to perform all of the duties of his/her job, the Covered County Employee will be eligible for Short Term Disability benefits provided he/she is under the regular care of a Physician and all terms and conditions of this program have been met.

9.01 *SHORT TERM DISABILITY TERMS*

Benefit Period shall mean the length of time (number of days) during which disability benefits are payable.

Covered Employee shall only include employees that have been employed for a minimum of six (6) months.

Received Medical Treatment shall mean that the Covered Employee consulted a licensed Physician, or was taking medication for the disabling condition.

Regular Physician Care shall mean the Covered Employee is being seen by his/her Physician on a regular basis, at a frequency deemed appropriate for the disabling condition, and at intervals necessary for the Physician to verify the continuing state of disability. For the purpose of this benefit, the Covered Employee must be seen by his/her Physician a minimum of once every thirty (30) days.

Total Disability and Totally Disabled shall mean a condition present whereby a person is unable to engage in duties of their regular occupation at their normal place of employment for their regularly scheduled amount of hours, or is unable to perform the normal activities of a person of like age and sex who is in good health, as a result of a covered Injury or Illness, and is under the regular care and attendance of a Physician who certifies the person's disability, and the person is not performing work of any kind for compensation or profit.

Waiting Period shall mean the number of consecutive days a Covered Employee must be totally disabled before benefit payments begin.

Weekly Earnings shall mean the basic weekly compensation averaged over the most recent twelve (12) week period, exclusive of overtime, bonuses or commissions, or any other compensation outside of their employment through the County. Disability benefit payments will not be paid during any period when an employee would not have normally received a paycheck.

9.02 *REQUIREMENTS TO ESTABLISH A SHORT TERM DISABILITY CLAIM*

a] The disabled employee must submit a disability claim form to the Claims Administrator, completed by the employee, the employer and the attending Physician. All three sections must be completed and signed by the persons indicated. The initial claim form must be submitted within ninety (90) days of the date the disability began.

b] In order for benefit eligibility to be established, the employee may be required to furnish copies of their medical records.

c] Any employee claiming disability may be subject to medical review at the Claims Administrator's request. Case review may be made by the Administrator's Utilization Review company and the employee may be required to submit to a medical evaluation for the purpose of a second opinion.

d] During the course of the disability benefit period, periodic requests will be made for updated medical information and/or a medical evaluation to establish continued disability status.

e] Disability benefits will begin after the Waiting Period of forty-five (45) days has been met and all accrued paid leave has been exhausted.

f] If a disabled employee returns to full-time work for ten (10) days or less during his/her Waiting Period, and then becomes disabled for the same condition, the Waiting Period will be extended by the number of days the employee returned to work (plus any weekends in between).

g] If a disabled employee returns to full-time work for more than ten (10) days during his/her Waiting Period, and then becomes disabled for the same condition, the employee will be required to satisfy a new Waiting Period in its entirety.

h] If an employee returns to work for at least one (1) full day and becomes disabled for a new and totally unrelated condition, a new Waiting Period must be satisfied and a new benefit period may be payable.

9.03 *BENEFIT CALCULATIONS*

a] The disability benefit will be calculated at sixty percent (60%) of the Covered Employee's weekly earnings. The weekly earnings will be the amount the Covered Employee was earning at the time the disability began. Disability benefit payments will not be affected by statutory or cost of living increases. Benefits payable are subject to the minimum stated in the Schedule of Benefits.

b] Disability benefits will be payable through the one hundred eightieth (180th) day of disability, or until the employee returns to work, or the Covered Employee is eligible for the Arizona State Long Term Disability benefits, or until the Covered Employee is no longer disabled, whichever occurs first.

c] Disability benefits shall be reduced by income received from any of the following sources:

- Disability benefits provided by no-fault auto insurance;
- Social Security disability benefits;
- Rehabilitation Income;
- Any salary, wages, commission or similar compensation payments;
- Loss of time benefits provided by any other group insurance contract.

If any of the above sources of income is received in a lump sum, the offset amount will be prorated over the number of weeks it represented. In no event will the benefits payable under this Plan be less than one hundred ($100) dollars per week after the above offsets are applied. Disability benefit payments will not be paid during any period when an employee would not have normally received a paycheck.

Benefits will not be payable concurrently with Retirement Benefits.

9.04 *SHORT TERM DISABILITY CONTINUATION OF BENEFITS*

a] Disability benefits will continue to be paid for up to the maximum number of days indicated in the Schedule of Benefits, provided the Covered Employee is continuously and totally disabled and meets all the eligibility requirements of this Plan.

b] If, during the course of a disability benefit period, the employee returns to active full-time or part-time work for thirty (30) days or less and then becomes disabled for the same or related condition, the reoccurrence will be considered a continuation of the original disability and therefore part of the same benefit period. A new Waiting Period will not be required and the benefits payable will be the remaining balance of the total allowable benefit days.

c] If the disabled employee returns to active employment for more than thirty (30) days and becomes disabled due to the same or related condition, benefits will only be payable if the recurrence of the disability is separated by six (6) months or more. Benefits will be subject to a new Waiting Period and a new benefit may be payable.

9.05 *SHORT TERM DISABILITY TERMINATION OF BENEFITS*

Benefits under this Plan will terminate at the time any of the following occurs:

- The date the Covered Employee is no longer disabled; or
- The date the Covered Employee fails to furnish the proper documentation that he/she continues to be disabled; or
- The date the Covered Employee is no longer under the care of a Physician; or
- The date the maximum number of benefit days has been paid; or
- The date the Covered Employee is eligible for the Arizona State Long Term Disability Plan; or
- The date the employee becomes eligible for retirement benefits.

9.06 *SHORT TERM DISABILITY LIMITATIONS AND EXCLUSIONS*

Short Term Disability benefits will not be payable if the disability was caused by any of the following:

- Injury or illness which arises out of, or occurs in the course of any occupation or while working for wage or profit.
- Any injury or illness for which the employee is entitled to benefits under the Workers Compensation Act or similar legislation.
- War, whether declared or undeclared.
- Civil disorder or riot.
- An injury or illness sustained while incarcerated or sustained during the commission of, or the attempted commission of, an assault, a felony or other criminal act whether or not there is a criminal charge or a conviction of a crime, if the offense is defined as a criminal act by the state in which the incident occurred, including injuries received while operating a motor vehicle in an illegal manner, driving while under the influence of alcohol or illegal drugs, negligent driving or driving at excessive speeds.
- Service in the Armed Forces of any Country.

ARTICLE X

COORDINATION OF BENEFITS

All medical and dental charges incurred by Covered Persons are subject to this "Coordination of Benefits" (COB) provision. This provision allows for coordination of this Plan's benefits with other "Applicable Policies" offering the same type of coverage to which the Covered Person may also be entitled.

Benefits will be coordinated so that the amount of benefits paid under this Plan along with the benefits received under all other applicable policies will not exceed the total allowable expense.

10.01 *GENERAL TERMS / PROVISIONS*

Allowable Expense means any necessary, reasonable and customary item of expense, a part of which is covered under one of the plans of the individual for whom the claim is made. If a contractual discount is made by the primary carrier, this Plan as secondary will only allow payments up to the contracted network allowance.

Applicable Policies means any of the following plans that provide coverage for hospital, surgical, medical or dental care: group plans (insured or noninsured); labor-management trusteed plans; union welfare plans; employer organization group plans; employee benefit organized plans; prepaid group practice; automobile first-party medical provision; group blanket or franchise insurance; benefits provided under Title XVIII of the Social Security Act of 1965 as amended (Medicare); any insurance or similar coverage.

COB Benefit Determination Period shall mean one (1) Calendar Year.

Primary Plan means the plan which initially pays its regular benefits.

Secondary Plan means the plan which pays the balance of the remaining Eligible Expenses after the Primary Plan has paid its complete liability. When the Secondary Plan's benefits are added to the Primary Plan's benefits, the total amount paid will not be more than the total allowable expense. In no event will the Secondary Plan's payment be greater than its normal liability would be had it been the Primary payer for all claims combined for the Calendar Year (accumulated credit savings can be used when necessary).

10.02 *ORDER OF BENEFIT DETERMINATION*

This Plan follows the guidelines established by the National Association of Insurance Commissioners (NAIC) when coordinating benefits.

1. The rules for determining primary vs. secondary for the order of benefit payments are as follows:
   a] A plan which does not have a non duplication of Benefits provision will pay as primary and this Plan will be secondary.
   b] The plan which covers the claimant as an Employee, member, subscriber or retiree shall be primary.
   c] The plan which covers the claimant as a Dependent shall be considered secondary.
   d] If a claimant is covered under one policy in an active status and is also covered under another policy in a retired or laid off status, the policy that covers the claimant in the active status will be primary.
   e] If a claimant has coverage under COBRA and is also covered under another plan in an active or retiree status, COBRA coverage would be secondary to active or retiree coverage.
   f] The benefits of a plan which covers the patient as a Dependent child whose parents are not separated or divorced shall have benefits determined according to the "Birthday Rule" as follows:
      1) The plan of the parent whose birthday (excluding year of birth) occurs earlier in the Calendar Year is primary over the plan of the parent whose birthday occurs later in a Calendar Year.
      2) If both parents have the same birthday, the plan which has covered a parent longer is primary before the plan which has covered the other parent for a shorter period of time.
   g] When none of the above determine which plan is Primary, the plan covering the person the longest will be Primary.

2. When Dependent children are covered under more than one plan as a result of a divorce or legal separation, the Primary Plan order of responsibility will be determined as follows:
   a] First: The plan where the dependent child is covered as a result of a divorce decree or court ordered "Qualified Medical Child Support Order" (QMCSO) which establishes financial responsibility for the medical expenses.
   b] Second: The plan of the natural or adoptive parent who has custody of the Dependent child.
   c] Third: The plan of the stepparent, provided the child's permanent primary residence is with the stepparent.
   d] Fourth: The plan of the natural or adoptive parent who does not have custody.
   e] Fifth: When the court decree does not specify which parent is responsible for the child's health care expenses, the "Birthday Rule" as defined above will apply.
   f] When none of the above determine which plan is Primary, the plan covering the Dependent child the longest will be Primary.

If none of the above rules determine which plan is Primary, each plan shall pay an equal share of the Covered Person's eligible expenses.

10.03 *COORDINATION WITH MEDICARE*

The term "Medicare" as used herein means the Medicare program established by Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended. A person shall be considered to be entitled to all of the coverage provided by Medicare on or after the earliest date he/she would have become so entitled had he/she promptly submitted all applications and proof required for such coverage, whether or not enrollment for such coverage or benefits has been made. A Covered Retiree should enroll in both Medicare Part A and Part B, as this Plan will coordinate benefits as if Medicare is primary for all service providers. This Plan adheres to all current regulations as determined by Medicare.

Medicare Order of Benefit Determination:

a] This Plan will be considered Primary for Active Employees and their Covered Dependents who are eligible for Medicare.
b] Medicare will be Primary and this Plan will be Secondary for Covered Retirees and their Covered Dependents who are eligible for Medicare.
c] Covered Persons who are Totally Disabled and under age sixty-five (65) will be considered Primary under this Plan and Secondary under Medicare.
d] This Plan will be Primary for Covered Persons entitled to Medicare due to end-stage renal disease (ESRD) for the first thirty (30) months of Medicare coverage, at which time Medicare will become the primary payer.
e] Medicare is primary over COBRA coverage except in the case of ESRD (refer to [d] above).

10.04 *PAYMENT TO THIRD PARTIES*

Whenever payments which should have been made under this Plan in accordance with the previous provisions have been made by any other plan, this Plan will have the right to pay to any organizations making these payments the amount it determines to be warranted in order to satisfy the intent of the previous provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, the Plan and the Employer will be fully discharged from liability under this Plan.

ARTICLE XI

DEFINITIONS

For the purpose of this Plan the following terms will have the following definitions when used in this document.

11.01 ACCIDENT means non-occupational bodily injury that is caused by an event that is external, violent, sudden and unforeseen, is not of gradual onset and is independent of all other causes or conditions.

11.02 ACTIVE means on a scheduled work day the employee is performing in the customary manner the regular duties of his/her employment on a full-time basis at the Employer's establishment or at some location to which the Employer's business requires him/her to travel.

11.03 ADMINISTRATOR or PLAN ADMINISTRATOR as defined by Federal Law means the Employer in the case of an employee benefit plan established or maintained by a single employer.

11.04 BIRTHING CENTER means a freestanding or hospital based, public or private institution, other than private offices or clinics of Physicians, which is licensed by the State as a Birthing Center or is associated with a licensed Hospital and meets official requirements of the State Department of Health.

11.05 CALENDAR YEAR means the twelve (12) month period of time from January 1 through December 31.

11.06 CHEMICAL DEPENDENCY means alcohol and/or drug dependence as defined in the current edition of the International Classification of Disease Manual (ICD) or the Diagnostic and Statistical Manual (DSM). See also definitions for Mental Health/Behavioral Health and Substance Abuse. Out-of-pocket expenses related to Chemical Dependency do not count towards the Covered Person's out-of-pocket limit.

11.07 CHIROPRACTOR is a practitioner who is duly licensed by the state (and acting within the scope of such license) to practice the science of chiropractic medicine.

11.08 CLAIMS ADMINISTRATOR means the company employed by the Plan who is responsible for the processing of claims and payment of benefits, administration, accounting and reporting as contracted for by the Plan. The current claims administrator is "Administrative Enterprises, Inc.".

11.09 CO-INSURANCE means the percentage of a claim that is the financial responsibility of the Covered Person after this Plan's eligible benefit percentage has been calculated.

11.10 COMPLEX DIAGNOSTIC SERVICES shall refer to extensive diagnostic procedures such as an MRI, CT Scan, PET Scan or any single diagnostic procedure that has an allowable amount of five hundred dollars ($500) or more.

11.11 CO-PAYMENT / CO-PAY means the specified dollar amount which a Covered Person must pay in conjunction with the receipt of Eligible Expenses under the terms of this Plan.

11.12 CORRECTIVE APPLIANCE means items which are prosthetic or orthotic and necessary for the restoration of function or replacement of body parts.

Prosthetic is an item used to replace all or part of a natural body part or the function thereof.
Orthotic is an item used to support a weakened body part or to correct a body defect.

11.13 COSMETIC refers to Treatment, Surgery or service performed which will preserve or improve appearance (i.e. reshape the structure) and which will not affect the physiological function.

11.14 COVERED DEPENDENT shall be those Dependents who are eligible according to the rules provided herein under Article II, "Eligibility", and are enrolled by a Covered Employee.

11.15 COVERED EMPLOYEE shall refer to an Employee who is eligible hereunder and who has been enrolled in the Plan. To be considered a Covered Employee, the individual must satisfy the requirements in Article II, "Eligibility".

11.16 COVERED PERSON shall refer to a Covered Employee, Covered Dependent, Covered Retiree or a Qualified Beneficiary under COBRA.

11.17 COVERED PRESCRIPTION DRUGS shall refer to any medication obtainable only upon a Physician's written prescription and which expenses are eligible for coverage and/or reimbursement in accordance with the then applicable prescription benefit provided by the Plan.

11.18 CUSTODIAL CARE shall mean services which are provided to help a person with personal hygiene or to perform activities of daily living and which can be safely performed by individuals who are not trained, licensed health care professionals. Services are custodial regardless of who recommends, orders, provides or directs the care or location for the care.

11.19 DEDUCTIBLE means the total amount of Eligible Expenses for services or supplies which the Covered Person must accumulate in Eligible Expenses prior to receiving benefit payment from this Plan.

11.20 DENTIST means a duly licensed practitioner acting within the scope of his or her license and holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

11.21 DRUG means any medication or article which may only be lawfully dispensed (as provided under the Federal Food, Drug and Cosmetic Act) upon the written or oral prescription of a Physician duly licensed by law to administer it.

11.22 DURABLE MEDICAL EQUIPMENT means equipment that can withstand repeated use, is not disposable, and is primarily and customarily used for a medical purpose and would not generally be useful in absence of Illness or Injury.

11.23 ELECTION PERIOD means the period in which each Qualified Beneficiary must elect coverage continuation. The period commences when the Covered Person becomes eligible or receives the notice specified in the Continuation of Coverage provision, whichever is later. The Election period terminates sixty (60) days after the receipt of the notice of rights under termination.

11.24 ELIGIBLE EXPENSES shall mean charges for services and supplies described in this Plan incurred as a result of a covered Injury or Illness by a Covered Person. For the purpose of these benefits, for a charge to be considered eligible the charge must be: a) administered or ordered by a Covered Physician; b) Medically Necessary; c) not of an experimental or investigational nature; d) not of a custodial nature; e) reasonable and customary treatment relative to the diagnosis; and f) a usual and customary amount for the service that is rendered or the item that is purchased as determined by the Plan or its designee. Charges for routine wellness care are also considered eligible expenses as covered under Article V, Section 5.35.

For a charge to be eligible the charge must be Usual, Customary and Reasonable for services and/or supplies that have been prescribed by a Physician for an Injury or Illness covered under this Plan. Eligible Expenses shall not include expenses which are specifically excluded or reduced as a result of specific Plan requirements not satisfied. Any amounts charged that are in excess of what the Plan determines to be the Usual, Customary and Reasonable amount will not be eligible under this Plan.

11.25 EMERGENCY means a sudden unexpected onset of a medical condition, which manifests itself by such acute symptoms of sufficient severity that requires urgent and immediate medical attention (without regard to the hour of day or night) to prevent significant impairment in bodily functions or serious and/or permanent dysfunction of any bodily organ or part and is not normally treatable in the provider's office.

11.26 EMERGENCY HOSPITALIZATION OR CONFINEMENT means a Hospital admission which takes place within twenty-four (24) hours of the onset of a sudden and unexpected severe symptom of an Illness or within twenty-four (24) hours of an accidental Injury during a life threatening situation.

11.27 EMERGENCY SURGERY shall mean a surgical procedure performed within twenty-four (24) hours of the sudden and unexpected severe symptom of an Illness or within twenty-four (24) hours of an accident during a life threatening situation.

11.28 EMPLOYER as used herein shall mean Cochise County, Cochise College or the Cochise Combined Trust member entity that provides eligibility under this Plan.

11.29 ENROLL means to make written application for coverage on the prescribed forms, within the stipulated timeframes.

11.30 ENROLLMENT DATE is the Covered Person's effective date on the Plan or, if earlier, the first day of the waiting period for this coverage (i.e. date of hire)

11.31 EXCLUSIVE PROVIDER ORGANIZATION (EPO) is a network of health care providers (i.e. Hospitals, Physicians, Laboratories, etc.) that have been contracted to provide services at a reduced rate. This Plan utilizes BlueCross BlueShield of Arizona and the Cochise Health Care System as its EPOs.

11.32 EXPENSE INCURRED shall mean the date on which the service or supply is actually rendered or obtained. Any agreement as to fees or charges made between the individual and the Physician shall not bind the Plan in determining its liability with respect to the Expense Incurred.

11.33 EXPERIMENTAL or INVESTIGATIONAL TREATMENT, PROCEDURE or EQUIPMENT means any services, procedures, equipment, drug treatments or supplies which:

a] Are considered by any governmental agency, such as the Food and Drug Administration (FDA), the National Institute of Health (NIH), or the The Centers for Medicare and Medicaid Services (CMS) as noted in the Medicare Coverage Issue Manual, to be experimental or investigational; or

b] Cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time a drug or device is furnished; or

c] "Reliable evidence" shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or

d] "Reliable evidence" shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or

e] Do not have a documented success ratio of fifty percent (50%) for a period of two (2) years.

"Reliable Evidence" shall mean published reports and articles in the authoritative medical and scientific literature, or the written protocol or written informed consent used by the treating facility or of another facility studying substantially the same drug, device, medical treatment or procedure.

11.34 GRACE PERIOD means the period of time in which the Covered Person/Qualified Beneficiary must pay the required contributions for continued coverage to remain in effect. The Grace period is thirty (30) days from premium due date. COBRA premiums are due the first day of each month and the Grace period ends thirty (30) days later.

11.35 HOME HEALTH CARE AGENCY shall mean a licensed public agency or private nonprofit organization which: a] is primarily engaged in providing skilled nursing services; and b] has policies, established by a group of professional personnel associated with the agency or organization (including one (1) or more Physicians and one (1) or more Registered Nurses), to govern and supervise the services which it provides (referred to in subdivision [a]) and provides for the supervision of such services by a Physician or Registered Nurse.

11.36 HOME HEALTH SERVICES shall mean the items and services which are furnished to a Covered Person who is under the care of a Physician. Such items and services may be furnished by a licensed Home Health Care Agency or by others under arrangements made by such an agency, under a plan established and periodically reviewed by such Physician. Such items and services shall be furnished on a visiting basis in the Covered Person's home or, if necessary, at the nearest facility equipped to provide such services when not available at the Covered Person's place of residence, and shall consist of any or all of the following:

a] A visit by a representative of a Home Health Agency of four (4) hours or less shall be considered as one (1) Home Health care visit.
b] Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse;
c] Physical therapy, occupational therapy, speech therapy, all of whom must be licensed to perform such services.

Such items and services may further consist of any or all of the following:

1) Medical social services under the direct supervision of a Physician;
2) Medical supplies (other than drugs and biologicals), and the use of medical appliances while under such a plan;
3) In the case of a Home Health Care Agency which is affiliated or under common control with a Hospital, medical services provided by an intern or resident in-training of such Hospital.

11.37 HOSPICE CARE shall mean services rendered for the care of patients who are dying of a terminal condition and have less than six (6) months to live and for whom traditional cure-oriented services are no longer medically appropriate. A Hospice Care program represents a coordinated, interdisciplinary program that provides services which consist of:

a] Inpatient or outpatient care, home care, nursing care, counseling and other supportive services and supplies provided to meet the physical, psychological, spiritual and social needs of the dying Covered Person; and
b] Instructions for care of the patient, counseling and other supportive services for the family of the dying Covered Person.

Hospice care charges are only eligible when rendered by an organization or institution that is approved by Medicare for payment.

11.38 HOSPITAL means a licensed institution engaged in providing for payment, care and treatment for sick and injured people, which meets all of the following requirements:

a] Provides care by Registered Nurses on call twenty-four (24) hours per day;
b] Has on staff at all times one (1) or more licensed Physicians; and
c] Has on its immediate premises (except in the case of an institution specializing in the care and treatment of psychiatric disorders) an operating room and related equipment for performing surgery.

The term *HOSPITAL* will not include a facility which is primarily for any of the following: rest or convalescence, custodial care, the aged, rehabilitation training, schooling, or occupational therapy. Confinement in a special unit of a Hospital (i.e. units primarily used as a nursing, rest or convalescent home) is not deemed as hospital confinement for purposes of this definition.

11.39 HOSPITAL MISCELLANEOUS CHARGES shall mean the Reasonable and Customary charges by the Hospital for the necessary services, medicine or supplies provided for the diagnosis or treatment of an illness or injury (except services of a Physician and drugs or supplies not consumed or used in the Hospital) while the Covered Person is Hospital confined and a charge is made for room and board, or if such services are rendered in connection with a surgical procedure performed on an "Outpatient" basis.

11.40 ILLNESS means bodily sickness or disease, pregnancy of an employee or spouse, psychiatric disorders, or congenital abnormalities.

11.41 IMMEDIATE FAMILY MEMBER shall mean the Covered Person's mother, father, sister, brother, husband, wife and/or child whether by birth or by marriage.

11.42 INDIVIDUAL DEDUCTIBLE AMOUNT is the amount shown in the Schedule of Benefits which must be accumulated in eligible expenses by a Covered Person during each Calendar Year before benefits are payable under this Plan.

11.43 INJURY means a condition which results independently of an Illness and is a result of an accidental externally violent force.

11.44 INJURY TO SOUND NATURAL TEETH shall mean an Injury to the teeth caused by an external object. Intrinsic force such as a force of chewing does not meet the definition of Injury.

11.45 IN-NETWORK refers to the "BlueCross BlueShield of Arizona" provider network and for mental health care the "Cochise Health Care Systems" network.

11.46 INPATIENT means confined in a Hospital facility for which a room and board charge has been made.

11.47 INTENSIVE CARE UNIT shall mean a section, ward, or wing within the Hospital which is separated from other Hospital facilities, and:

a] Is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; and
b] Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use; and
c] Provides room and board and constant observation and care by Registered Nurses and other specially trained Hospital personnel.

11.48 LIFE THREATENING means unexpected, acute, sudden and serious conditions which require *immediate* medical treatment.

11.49 LIFETIME MEDICAL/Rx MAXIMUM means the maximum medical and prescription benefits available for any one (1) Covered Person for all conditions during his/her lifetime while covered under this Plan, whether or not there has been any interruption in his/her coverage under this Plan.

11.50 MEDICALLY NECESSARY OR MEDICAL NECESSITY means any health care, service, supplies, or accommodations received by the Covered Person for Illness or Injury which is consistent with the following criteria as determined by the Plan or its designee:

a] Must be consistent with the symptom(s) or diagnosis;
b] Must be received in the most appropriate setting that can be used safely (for example, in a Provider's office or Ambulatory Surgery Service Facility instead of a Hospital);
c] Must not be solely for the convenience of the Covered Person, the Physician, the Hospital, healthcare provider or any other person;
d] Must be the most appropriate with regard to standards of good medical practice and could not have been omitted without adversely affecting the Covered Person's condition or the quality of medical care received, as determined by established medical review mechanisms;
e] Must be the most appropriate and cost efficient level of service that can be safely provided to the Covered Person.

The fact that a Physician may recommend or approve a service or supply does not in itself make the service or supply Medically Necessary.

11.51 MEDICARE means Title XVIII of the United States Social Security Amendment of 1965 (Federal Health Insurance for the Aged), or as later amended.

11.52 MENTAL HEALTH / BEHAVIORAL HEALTH refers to disorders, conditions and diseases as defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-9-CM) manual, and is not a specific Plan exclusion. Out-of-pocket expenses related to mental health/behavioral health do not count towards the Covered Person's out-of-pocket limit.

11.53 MENTAL HEALTH / BEHAVIORAL HEALTH TREATMENT FACILITY shall mean a public or private facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of mental health disorders, and provides skilled nursing care by licensed nurses under the direction of a full-time R.N. The facility must have at least one Physician on staff and on call. The facility must prepare and maintain a written plan of treatment for each patient. The treatment plan must be based on medical, psychological and social needs.

11.54 NEWBORN NURSERY CHARGES means the room and board and miscellaneous charges made by a Hospital for the care (DRG 795), other than for an illness or injury, of a newborn baby immediately following birth.

11.55 NONDURABLE means goods and supplies which cannot withstand repeated use and/or are considered disposable and limited to a one-person or one-time use, including but not limited to diapers, incontinence pads, soap, etc.

11.56 NURSE means a Registered Graduate Nurse (R.N.), a Licensed Vocational Nurse (L.V.N.), a Licensed Practical Nurse (L.P.N.), or a Registered Nurse First Assistant (RNFA).

11.57 NURSE-MIDWIFE means a Certified Nurse-Midwife holding the degree of C.N.M. and practicing within the scope of his/her license. Services rendered must only be for obstetrical care or well woman care.

11.58 ORTHOGNATHIC refers to services dealing with the cause and treatment of malposition of the bones of the jaw.

11.59 ORTHOTICS means a corrective appliance customized and dispensed by a certified orthotics laboratory to support weakened feet.

11.60 OUT-OF-NETWORK means any provider that is not contracted with BlueCross BlueShield of Arizona or Cochise Health Care System.

11.61 OUT-OF-POCKET MAXIMUM means the total dollar amount of eligible charges which is accumulated per person and paid at the co-insurance percentage, after which the Plan will pay Eligible Expenses for the remainder of the Calendar Year at one hundred percent (100%). Expenses for mental health care/substance abuse/chemical dependency, co-payments and penalties for noncompliance with pre-certification requirements do not accumulate toward the out-of-pocket limit.

11.62 OUTPATIENT shall mean any care or treatment that is rendered while the Covered Person is not confined in a Hospital or other Facility.

11.63 PARTICIPATING or PREFERRED PROVIDER means a provider who is under contract with the Blue Cross BlueShield of Arizona network to provide services to Covered Persons at negotiated rates.

11.64 PERIOD OF COVERAGE means the period beginning on the date of the Qualifying Event and lasting until the earliest of the dates indicated under Article IV, Continuation of Coverage (COBRA).

11.65 PHYSICIAN OR DOCTOR means a duly licensed or certified practitioner acting within the scope of his/her license or certification and holding the degree of:

a] M.D. - Doctor of Medicine
b] D.O. - Doctor of Osteopathy
c] P.A. - Physician's Assistant
d] N.P. - Nurse Practitioner
e] DPM – Doctor of Podiatry

The services of a Physician's Assistant (P.A.) will be eligible provided they are operating under the direct supervision of an M.D. or a D.O. An eligible Physician shall not include the Covered Person, or a Physician who is part of the Covered Person's family.

11.66 PLAN shall mean the benefits provided through the Cochise Combined Trust as described in this Plan Document.

11.67 PLAN DOCUMENT shall mean and refer to this written document, any amendments thereto, and any successor document that states the benefits provided by the Trust.

11.68 PRACTITIONER shall mean a person acting within the scope of applicable state licensure/certification requirements and holding the degree of Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Registered Physical Therapist (RPT), Occupational Therapist, Speech Therapist, Physician's Assistant (PA), Certified Surgical Assistant (CSA), Registered Nurse First Assistant (RNFA), Nurse Practitioner (NP) or Registered Respiratory Therapist. An eligible practitioner shall not include the Covered Person, or anyone who is a member of the Covered Person's family or resides with the Covered Person. Eligible Mental Health/Behavioral Health practitioners are limited to Psychiatrist, Psychologists, Certified Professional Counselors, and social workers with a master's degree in behavioral science (provided they are working under the direct supervision of a Physician, a Psychiatrist or a Psychologist). Optometrists administering topical pharmaceutical agents or removing superficial foreign bodies from the eye must be appropriately licensed and meet any additional state requirements for such services.

11.69 PRE-CERTIFICATIO*N* refers to the process of reviewing the necessity, appropriateness, location, duration and/or cost efficiency of a health care service before it is rendered.

11.70 PRE-EXISTING CONDITION means any condition for which an individual was diagnosed, received medical care or treatment (including but not limited to diagnostic testing, consultation, or consumption of prescribed medication, or self-administered drugs or biologicals) during the six (6) month period immediately preceding his/her date of hire or enrollment date, whichever is later, for coverage with this Plan. Under this plan condition means any disease, illness, ailment or bodily malfunction of a Covered Person. Under this plan treatment means medical or surgical management of a Covered Person. Under this plan consultation means the seeking or rendering of medical treatment by or from a physician or doctor. Under this plan biologicals means any natural compound processed and used for the treatment and/or cure of a medical condition.

11.71 PROSTHETICS means a corrective appliance customized to replace all or part of a missing body part as an artificial limb.

11.72 QUALIFIED BENEFICIARY shall mean a person so defined under Article IV, Continuation of Coverage (COBRA).

11.73 QUALIFYING EVENT as used and defined under Article IV, Continuation of Coverage (COBRA).

11.74 RECONSTRUCTIVE SURGERY shall mean a procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease, tumor, or for breast reconstruction following a mastectomy.

11.75 REHABILITATION/REHABILITATION THERAPY shall mean physical, occupational and speech therapy prescribed by a Physician and performed by licensed therapists, to improve body function that has been restricted or diminished as a result of illness, injury or surgery. The Plan covers active rehabilitation which refers to therapy in which the patient actively participates and is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform their normal body function.

Passive rehabilitation refers to therapy in which the patient does not actively participate because of a cognitive deficit, is comatose or otherwise physically or mentally incapable of active participation. Maintenance rehabilitation refers to therapy in which the patient actively participates and has met the functional goals of the active rehabilitation so that no continued improvement is anticipated but where additional therapy may be prescribed to maintain, support and/or preserve the patient's functional level.

11.76 RESIDENTIAL TREATMENT FACILITY means a facility duly licensed or certified by the State Department of Health for treatment of chemical dependency or substance abuse.

11.77 ROUTINE NEWBORN / WELL BABY CARE means charges made by a Provider for inpatient (DRG 795) or outpatient examination or care of a healthy newborn or infant other than treatment or diagnosis in connection with an Illness or Injury.

11.78 SEMIPRIVATE ROOM CHARGE means the charge by a Hospital for a room containing two (2) or more beds.

11.79 SKILLED NURSING CARE refers to services performed by a licensed health care professional which:

a] Has been ordered and provided under the direct supervision of a Physician;
b] Is intermittent and part-time, not exceeding sixteen (16) hours per day and typically is required on less than a daily basis;
c] Requires the skills of technical or professional personnel in that the service is so inherently complex that it can only safely and effectively be performed by same.

11.80 SKILLED NURSING FACILITY (SNF) OR EXTENDED CARE FACILITY shall mean an institution, or a distinct part thereof, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from injury or illness, and:

a] Is approved by and is a participating Skilled Nursing Facility under Medicare; and
b] Has organized facilities for medical treatment and provides twenty-four (24) hour nursing services under the full-time supervision of a Physician or Registered Nurse; and
c] Maintains daily clinical records on each patient and has available the services of a Physician under the established agreement; and
d] Provides appropriate methods of dispensing and administering drugs and medicines; and
e] Has transfer arrangement with one or more Hospitals, a utilization review plan in effect and an operations policy developed with the advice of, and reviewed by, a professional group including at least one Physician; and
f] Is not an institution or part thereof which is primarily a place of rest, a place for custodial care, a place for the aged, a hotel or similar institution.

11.81 SPINAL MANIPULATION AND CHIROPRACTIC CARE means the treatment rendered for the correction of structural imbalance, distortion, misalignment or subluxation of or in the vertebral column by manual or mechanical means.

11.82 SOUND AND NATURAL TEETH means a tooth which is free of decay or periodontal disease, contains a live nerve and root, and has never been capped or crowned.

11.83 SUBSTANCE ABUSE means alcohol and/or drug dependence as defined in the current edition of the International Classification of Disease Manual (ICD) or the Diagnostic and Statistical Manual (DSM). See also definitions for Mental Health/Behavioral Health and Chemical Dependency. Out-of-pocket expenses related to Substance Abuse do not count towards the Covered Person's out-of-pocket limit.

11.84 SURGERY means any of the following medical procedures:

a] To incise, excise, or electrocauterize any organ or body part;
b] To repair, revise or reconstruct any organ or body part;
c] To reduce by manipulation a fracture or dislocation;
d] To puncture or aspirate;
e] Use of a scope for diagnostic procedures;
f] Use of endoscopy or laparoscopy, etc. for exploration or removal of tissue;
g] Use of a Laser;

In the case of multiple surgeries performed through the **same incision** the maximum allowable expense shall be equal to the Usual, Customary and Reasonable amount for the procedure with the greatest scheduled amount. Additional allowances (modifiers) may be given when the additional surgeries add significant complexity to the surgical session. If during the same surgical session multiple surgeries are performed through **separate incisions**, the allowable expense shall be calculated at the full UCR amount of the primary procedure, and at fifty percent (50%) of the UCR amount of each of the lesser procedure(s) that are through their own separate incision(s).

11.85 SURGICAL CENTER, FREESTANDING OR AMBULATORY means a hospital based or freestanding legally operated center which;

a] Has permanent operating rooms and at least one (1) recovery room, and all necessary equipment for use before, during and after surgery; and
b] Is other than a private office or clinic of a Physician; and
c] Has full-time Registered Nurses available for care in an operating room or recovery room; and
d] Has a contract with at least one (1) nearby Hospital for immediate acceptance of patients who require Hospital care following care in the freestanding facility; and
e] Is supervised by an organized staff of medical professionals.

11.86 TOTAL DISABILITY means a condition present whereby a person is unable to engage in duties of their regular occupation at their normal place of employment for their regularly scheduled amount of hours, or is unable to perform the normal activities of a person of like age and sex who is in good health, as a result of a covered Injury or Illness, and is under the regular care and attendance of a Physician who certifies the person's disability, and the person is not performing work of any kind for compensation or profit.

11.87 TREATMENT shall mean having received a diagnosis, consultation, or taking prescribed drugs/medication (including self-administered drugs or biologicals not requiring a Physician's prescription) for an Illness or Injury.

11.88 URGENT CARE FACILITY is a public or private Hospital based or free-standing facility that is licensed or legally operating as an Urgent Care Facility that primarily provides minor emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

11.89 USUAL, CUSTOMARY AND REASONABLE (UCR) means the normal charges of the provider for a service or supply, but not more than the prevailing charge in the same geographical area for a like service or supply. A charge is "usual" when it corresponds to the going charge for a given service by a provider of medical services. The charge is "customary" when it is within the range of usual charges made by providers of medical services, with similar training and experience, for the same service within the same specific and limited geographical area. The charge is considered "reasonable" when it meets the foregoing criteria, and, in the opinion of responsible medical authorities, it is justifiable considering the special circumstances of the particular case in question. With respect to EPO/PPO providers, the UCR charge is defined as the fee allowance as outlined in the agreements between the EPO/PPO providers and the EPO/PPO.

11.90 VISIT shall mean an in person interview/consultation between a Physician or other eligible health care practitioner and a Covered Person.

ARTICLE XII

GENERAL PROVISIONS

The Plan Document constitutes the entire Plan. The Plan does not constitute a contract of employment or in any way affect the right of the employer to discharge any employee. If the language in this Plan Document conflicts with the Schedule of Benefits, the Schedule of Benefits will be considered correct and benefits paid accordingly.

12.01 *PURPOSE*

Your employer has established and maintains the self-funded Employee Benefit Trust contained herein to provide for the payment or reimbursement of specified medical expenses incurred by its Covered Employees and their Covered Dependents. The name of the Plan is the Cochise Combined Trust, hereinafter referred to as the "Plan". The purpose of this Plan Document is to set forth the provisions of the Plan which provide and/or affect such payment or reimbursement.

12.02 *EFFECTIVE DATE*

The revised Effective Date of the Plan is July 1, 2009 as of 12:01 a.m., Mountain Standard Time in the State of Arizona. Eligibility for, and the amount of benefits, if any, payable with respect to employees of the Employer or their dependents, prior to the effective date, shall be determined in accordance with any applicable group benefit plan maintained by the Employer at that time. As of the effective date, eligibility for, and the amount of benefits, if any, payable with respect to employees of the Employer or their dependents, shall be determined pursuant to the terms and conditions of this Plan Document.

12.03 *AMENDMENTS*

To carry out its obligation to maintain, within the limits of the funds available to it, a sound economic program dedicated to providing quality benefits for Covered Employees and Covered Dependents, the Trust expressly reserves the right, at its sole discretion and without notice to eligible individuals but on a nondiscriminatory basis to:

a] Cancel or discontinue the Plan;
b] Amend either the amount or conditions with respect to any benefits or provisions of the Plan, even though such amendment affects the claims in process and/or expenses already incurred;
c] Determine initial and/or continuing eligibility for receipt of benefits by Plan beneficiaries, including elected/appointed officials and/or their dependents, active Employees and/or their Dependents and such other categories or classes of beneficiaries as the Trust may from time to time establish;
d] Alter or postpone the method of payment of any benefit; and
e] Amend any provisions of this Summary Plan Description.

12.04 *SUMMARY PLAN DESCRIPTIONS*

Each employee covered under this Plan will receive a Summary Plan Description (this document) describing the benefits to which the Covered Persons are entitled, to whom benefits are payable, and summarizing the provisions of the Plan.

12.05 *MISREPRESENTATION OR FRAUD*

In the event of misrepresentation or fraud by a Covered Person or by a Covered Person's representative, the Plan has the right to deny claims in whole or in part. If information is misrepresented on an application for coverage, this Plan has the right to rescind coverage.

12.06 *MISSTATEMENT OF AGE*

If the age of a covered individual has been misstated and if the amount of contribution is based on age, an adjustment of contributions shall be made based on the covered individual's true age. If age is a factor in determining eligibility or amount of benefits, or both, the amount for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

12.07 *DISCLAIMER OF LIABILITY*

The Plan has no control over any diagnosis, treatment, care (or lack thereof), or other services delivered to a Covered Person by a provider, and disclaims liability for any loss or injury caused to the Covered Person by any provider by reason of negligence, or failure to determine the correct diagnosis, or failure to provide treatment or otherwise.

12.08 *PRIVACY, CONFIDENTIALITY, RELEASE OF RECORDS OR INFORMATION*

Any information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without your written consent, except as follows:

a] Information will be disclosed to those who require that information to administer the Plan or to process claims.

b] Information with respect to duplicate coverages will be disclosed to the plan or insurer that provides the duplicate coverage.

c] Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.

12.09 *RIGHT TO RECEIVE AND RELEASE INFORMATION*

For the purpose of implementing the terms of this Plan, information may be released to or obtained from any insurance company, organization or individual, concerning any Covered Person when it is deemed necessary. Any Covered Person claiming benefits under this Plan will furnish the Plan the information necessary to implement the Plan provisions. The Plan reserves the right to suspend or deny a claim based on lack of information and/or records.

ARTICLE XIII

MISCELLANEOUS PLAN PROVISIONS

13.01 ***FILING OF INFORMATION***
Each Covered Person is responsible to file with Cochise Combined Trust, all pertinent information concerning eligibility, name and address changes, marriage, divorce, disability, Medicare eligibility, information regarding "Other Insurance", death, student status, and proof or continued proof of dependency, within thirty-one (31) days of the event, in order to be entitled to benefits under the Plan.

13.02 ***PROOF OF CLAIM and TIMELY FILING REQUIREMENTS***
Written notice and proof of claim hereunder must be given to the Plan with the particulars sufficient to identify the Covered Person and the medical necessity for the services rendered, within twelve (12) months of the date such claim was incurred. The Covered Person must submit properly completed claim forms, itemized original statements, and other medical documentation as required by the Plan. If a claim has been closed for lack of response to requests for information, the Covered Person has a maximum of one hundred eighty (180) days from the date the claim was closed to provide the additional information. Any exceptions to these filing requirements are subject to approval by the Board of Trustees.

13.03 ***INTERPRETATION OR PLAN PROVISIONS***
The Claims Administrator shall have the discretion to interpret and apply the provisions of this Plan, subject to review by the Plan Trustees. The Plan Trustees have sole discretion in appeal and/or other review processes.

13.04 ***PREFERRED PROVIDER ARRANGEMENT***
The Board shall have the right to contract with Providers or existing networks of Providers in order to establish a Preferred Provider Network. All other Plan restrictions and limitations will remain the same.

13.05 ***INDEPENDENT PHYSICIAN EXAMINATION***
The Plan, at its own expense, shall have the right and opportunity to have a Physician of its choice examine the Covered Person when and so often as it may reasonably require during the pendency of any claim.

13.06 ***MANAGED CARE RECOMMENDATIONS***
This Plan, along with the Utilization Review firm and the Claims Administrator, have the option of overriding certain Plan limitations, exclusions or pre-certification requirements when it is in the best interest of the Plan to allow a more cost effective type of alternative care.

13.07 ***FACILITY OF PAYMENT***
If a valid release cannot be rendered for the payment of any benefit payable under this Plan, payment may be made to the individual or individuals that have assumed the care and support of the Covered Person and are, therefore, entitled thereto. In the event of the death of the Covered Person prior to such times as all benefit payments due him/her have been made, benefit assignments made prior to the death of the Covered Person will be honored. Any payment in accordance with the above provisions shall fully discharge the obligation of the Plan to the extent of such payments.

13.08 ***ASSIGNMENT***
The Covered Person's benefits may not be assigned, other than to the provider of service, except by consent of the Plan. This Plan contains an automatic assignment of benefits to the provider of service unless evidence of previous payment is submitted with the claim. Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to the Covered Person.

13.09 *RIGHT OF RECOVERY*

If for any reason payments are made in excess of the correct amount due, the Plan has the right to recover any excess payments from any other company, organization, or individual, including the reduction or suspension of future Plan benefits that may be due the Covered Person or any Covered Family Member, or, by requiring the Covered Person to pay back the overpayment in full or in accepted and approved installments until the overpayment is fully recovered.

13.10 *THIRD PARTY RECOVERY/SUBROGATION*

The Plan has a first priority Subrogation and Reimbursement right if it provides benefits resulting from or related to an injury, occurrence, or condition for which the eligible person has a right of redress or recovery against any Third-Party.

What does first priority right of Subrogation and Reimbursement mean? It means that if the Plan pays benefits which are, in any way, compensated by a Third-Party, such as an insurance company, you agree that when a recovery is made from that Third-Party, the plan is fully reimbursed out of that recovery for the benefits the Plan previously paid. If you do not agree to the Plan's Subrogation and Reimbursement rules, benefits will not be paid.

The rights of Subrogation and Reimbursement are incorporated into this Plan for the benefit of each participant in recognition of the fact that the value of benefits provided to each participant will be maintained and enhanced by enforcement of these rights.

Subrogation and Reimbursement - Rules for the Plan

The following rules apply to the Plan's rights of Subrogation and Reimbursement:

a] Subrogation and Reimbursement Rights in Return for Benefits: In return for the receipt of benefits from the Plan, the eligible person agrees that the Plan has the Subrogation and Reimbursement rights as described in this Subrogation and Reimbursement section. Further, the eligible person, or the eligible member for his/her minor dependent will sign, if requested, a form acknowledging the Plan's Subrogation and Reimbursement rights prior to payment, or further payment, of benefits. Benefits will not be paid if the eligible person refuses to sign the acknowledgment. Regardless of whether the eligible person refuses to sign the acknowledgement form, or if the acknowledgment form is not requested, the Plan's Subrogation and Reimbursement rights to benefits paid are not waived, or limited in any way.

b] Constructive Trust or Equitable Lien: The Plan's Subrogation and Reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the eligible person from a Third-Party, whether by settlement, judgment, or otherwise. When a recovery is obtained, the recovered proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovered proceeds in trust, which in no way prejudices or adversely impacts the Plan's Subrogation and Reimbursement rights. The Plan reserves the right to, among other things, pursue all available equitable actions and offset any future benefits payable to the eligible person under the Plan.

c] Plan Paid First: Amounts recovered or recoverable by or on the eligible person's behalf are paid to the Plan first, to the full extent of its Subrogation and Reimbursement rights, and the remaining balance, if any, to the eligible person. The Plan's Subrogation and Reimbursement right comes first even if the eligible person is not paid for all of their claims for damages. If the Plan 's Subrogation and Reimbursement rights are not fully satisfied directly by a Third-Party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the eligible person may have received or may be entitled to receive from the Third-Party.

d] Right to Take Action: The Plan's right of Subrogation and Reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan and any Plan member can bring an action (including in the eligible person's name) for specific performance, injunction, or any other equitable action necessary to protect its rights in the cause of action, right of recovery, or recovery by an eligible person. The Plan will commence any action it deems appropriate against an eligible person, an attorney, or any Third-Party to protect its Subrogation and Reimbursement rights. These Subrogation and Reimbursement rights apply to claims of eligible dependents covered by the Plan regardless of whether such dependent is legally obligated for expenses of treatment.

e] Applies to all Rights of Recovery or Causes of Action: The Plan's Subrogation and Reimbursement rights apply to any and all rights of recovery or causes of action the eligible person has or may have against any Third-Party.

f] No Assignments: The eligible person cannot assign any rights or cause of action they may have against a Third-Party to recover medical expenses without the express written consent of the Plan.

g] Full Cooperation: The eligible person will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's Subrogation and Reimbursement rights. Benefits will be denied if the eligible person does not cooperate with the Plan. Repayment to the Plan is to be made within sixty (60) days of the receipt of the settlement or judgment payment from the Third-Party.

h] Notification to the Plan: The eligible person must promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity to pay the member for their injuries, sickness, or death. Further, the eligible person must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims.

i] Third-Party: Third-Party includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, worker's compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate or pay for a member's loss, damage, injuries, or claims relating in any way to the injury, occurrence, conditions, or circumstances leading to the Plan's payment of benefits. This right of Subrogation and Reimbursement exists regardless of whether the policy of insurance is owned by the eligible person.

j] Apportionment, Comparative Fault, Contributory Negligence, Make-Whole, and Common-Fund Doctrines Do Not Apply: The Plan's Subrogation and Reimbursement rights include all portions of the eligible person's claim regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a spouse for loss of consortium. The Plan's Subrogation and Reimbursement rights are not affected, reduced, or eliminated by comparative fault, contributory negligence, the make-whole and/or common-fund doctrines, or any other equitable defenses.

k] Attorney's Fees: The Plan will not be responsible for any attorneys' fees or costs incurred by the eligible person in any legal proceeding or claim for recovery, unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorneys' fees or costs.

l] Course and Scope of Employment: If the Plan has paid benefits for any injury which arises out of and in the course and scope of employment, the Plan's right of Subrogation and Reimbursement will apply to all awards or settlements received by the eligible person regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorneys' fees are awarded to the eligible person's attorney from the Plan's recovery, the eligible person will reimburse the Plan for the attorneys' fees.

13.11 *SETTLEMENT OF DISPUTE*

No Covered Person, Covered Dependent or other beneficiary shall have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to eligibility, type, amount or duration of benefits under this Plan or any amendment or modification thereof shall be resolved by the Board of Trustees under and pursuant to this Plan Document. The decision of the dispute shall be final and binding upon all parties to the dispute. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right hereunder, until after the claim has been submitted to and determined by the Board of Trustees. Thereafter the only action which may be brought is one to challenge the decision of the Plan Sponsor. No such action may be brought unless brought within one year after the date of such determination.

13.12 *BENEFITS EXEMPT FROM ATTACHMENT*

To the full extent permitted by law, all rights and benefits under this policy are exempt from execution, attachment, garnishment, or other legal or equitable process for the debts or liabilities of any Covered Person or any beneficiary.

13.13 *REGULATORY REPORTING*

The Plan Administrator shall be responsible for filing all reports and accounting which governmental regulatory bodies may require. It shall be the Board's duty and responsibility to provide the Plan Administrator with such information, upon request and as deemed necessary, to prepare such required reports and accounting and to reasonably assist in the preparation of such reports and accounting to the extent requested by the Plan Administrator.

13.14 *INDEMNIFICATION OF TRUSTEES*

A person who accepts trusteeship duty, with respect to the Plan, shall be indemnified by the Trust against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses incurred in the defense of any claim relating thereto.

ARTICLE XIV

CLAIM FILING PROCEDURE

14.01 This Plan has incorporated the BlueCross BlueShield of Arizona network into the benefit program. All medical claims submitted are reviewed and repriced in accordance with the applicable negotiated fee schedule. Administrative Enterprises, Inc. (AEI) has partnered with Blue Cross Blue Shield of Arizona for electronic claims submission. Electronic claims will be routed via BCBS of AZ for re-pricing and then will be forwarded to AEI by BCBS of AZ for processing. Claims submitted via paper will be submitted directly to AEI for processing.

To be eligible for processing, claims submitted must be original itemized statements and include the following:

a] Patient name;
b] Diagnosis;
c] Date of service;
d] Description of each service rendered, including procedure codes;
e] Amount charged for each service; and
f] The provider's signature, title/credentials, address and tax identification number.

Balance due statements, photocopies, cash register receipts, canceled checks or credit card receipts will not be acceptable as proof of charges incurred.

14.02 If the Covered Person must file a claim directly to AEI, obtain and complete an AEI claim form. Claim forms can be obtained directly from Administrative Enterprises, Inc. or the employer.

14.03 The completed claim form should be attached to the itemized statement, and submitted to AEI for processing.

14.04 Benefits will automatically be assigned to the provider of service unless the bills are clearly marked as paid.

14.05 Claims must be submitted to AEI on a timely basis (as stated in Article XIII, Section 13.02) in order to be eligible for benefit consideration. AEI will accept charges that are submitted within twelve (12) months of the date the charge was incurred.

14.06 AEI's mailing address for Medical claims:

Administrative Enterprises, Inc.
5810 West Beverly Lane
Glendale, Arizona 85306-1800

14.07 For claim inquiries contact:

Administrative Enterprises, Inc.
(602) 789-1170 / (800) 762-2234
www.aeitpa.com

14.08 For eligibility information and benefit descriptions:

Administrative Enterprises, Inc.
Fax: **(602) 789-9369**
www.aeitpa.com

ARTICLE XV

CLAIMS APPEAL PROCEDURE

15.01 In the event that a claim is denied in whole or in part, the Covered Person, or his or her duly authorized representative, may:

a] Inspect and obtain copies of the documents and information in the claim file used to deny the claim. Such requests are to be made in writing to the Claims Administrator (or the Plan Consultant for Prescription Drugs). Any actual inspection will take place during regular business hours of the Claims Administrator (or the Plan Consultant for Prescription Drugs) and at the location designated by the Claims Administrator (or the Plan Consultant for Prescription Drugs).

b] File a written request for a review of the denied claim by submitting such request to the Claims Administrator (or the Plan Consultant for Prescription Drugs) no later than sixty (60) days from the date of the initial written denial of the claim.

c] Submit any additional documentation to the Claims Administrator (or the Plan Consultant for Prescription Drugs) to support a request for review.

15.02 Upon receipt of the Covered Person's written request for review, the Claims Administrator (or the Plan Consultant for Prescription Drugs) will, within thirty (30) days of receipt:

a] Review the claim denial and all submitted documentation to determine if the claim denial was appropriate; and

b] Provide the Covered Person a written decision concerning the claim denial review including both the specific reasons for their claim review determination and specific reference to the provisions within the Plan that controlled the decision.

15.03 If upon review the claim is again denied, the Covered Person may appeal the denial to the Board of Trustees. The appeal must be made in writing and sent to the Plan Consultant within sixty (60) days of the first level appeal denial notification. The Covered Person may include with their appeal any additional information or documentation not previously submitted to the Claims Administrator (or the Plan Consultant for Prescription Drugs). They may also be present by phone or in person to present their appeal, but this is not a substitute for the required written appeal. Upon receipt of the written request for appeal, the Board of Trustees, at their next regularly scheduled meeting, will:

a] Hear the appeal and render a decision in the matter; or

b] Designate a hearing officer to review evidence, prepare a record and present a recommendation to the Board of Trustees for decision. The Hearing Officer is appointed and will hear the appeal within forty-five (45) days. The Hearing Officer may extend the time by agreement of the parties. Upon conclusion of the Hearing, the Hearing Officer shall issue written findings and recommendations to the Board of Trustees. Within fifteen (15) calendar days of receipt of the Hearing Officer's recommendations, the Board of Trustees shall meet to render a final appeal decision.

c] The Covered Person will be sent a written notice of the Board of Trustees final appeal decision within thirty (30) days following the Board of Trustees meeting. The decision of the Board of Trustees shall be final and binding on all parties to the dispute.

15.04 A BlueCross BlueShield of Arizona Contracted Provider has twelve (12) months from the date of the original payment to appeal a pricing issue with BlueCross BlueShield of Arizona. If the corrected pricing is received by the Claims Administrator within thirty (30) days of the provider's appeal, a claims adjustment will be allowed.

15.05 Any requests for review or appeal that do not comply with the procedure set forth above, or are not brought within the time limits set forth above, will not be considered for review or appeal.

ARTICLE XVI

NOTICE OF PRIVACY PRACTICES

(As required by 45 Code of Federal Regulations Parts 160 & 164)

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact
Cochise Combined Trust's Privacy Officer
c/o Erin P. Collins & Associates, Inc.
1115 Stockton Hill Road, Suite 101
Kingman, Arizona 86401
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This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health conditions and the provision or payment of related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. We will provide you with any revised Notice of Privacy Practices upon your request to the Privacy Officer identified above. Requests may be sent to the Privacy Officer via telephone, fax, email or mailing to the numbers or addresses shown above. Alternatively, you may request any revised Notice of Privacy Practices by contacting your employer's Personnel or Human Resources Department.

A. Uses and Disclosures of Protected Health Information Without Your Consent or Authorization.

Cochise Combined Trust (CCT) may have access to and use your protected health information for reasons consistent with applicable provisions of federal and state law. These uses will be confined to reasons related to treatment, payment and operations. Following are examples of the types of uses and disclosures of your protected health care information that CCT is permitted to make without your consent. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by CCT in the course of administering the employee benefits provided to you by your employer through its membership in CCT.

1. **Treatment**: CCT may use and disclose your protected health information for purposes of determining the eligibility of proposed benefits for reimbursement through CCT and, where such treatments are in fact covered under CCT's plan of benefits, paying any and all resulting claims as presented to CCT through its third party administrator (TPA) and in accordance with the applicable summary plan description.

2. **Payment**: Your protected health information will be used, as needed, to make payment to providers who have cared for you in accordance with the provisions of the benefit plan provided through CCT. This may include certain activities that CCT may undertake before it approves or pays for the health care services your physician recommends for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, undertaking utilization review activities and resolving appeals related to benefit and/or claims payment denials.

3. **Healthcare Operations**: We may use or disclose, as-needed, your protected health information in order to support the business activities of CCT. These activities include, but are not limited to, placement of contracts of insurance or reinsurance, seeking reimbursement of eligible medical payments from CCT insurers or reinsurers, seeking reimbursement or repayment from third parties via subrogation, auditing the appropriateness of claims processing or payment activity of CCT vendors, developing and implementing health and wellness promotion programs and conducting or arranging for other CCT business activities.

In completing treatment, payment and operational activities, CCT may share your protected health information with third party "business associates" that perform various activities (e.g., pre-certification of certain medical procedures and hospital admissions, payment of claims and reimbursement-related activities with insurers and reinsurers) for CCT. Whenever an arrangement between CCT and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that seek to protect the privacy of your protected health information. Further uses and disclosure of PHI without your consent or authorization is permitted for the following public policy purposes:

1. **Required By Law**: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

2. **Public Health**: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3. **Legal Proceedings**: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process, but only if reasonable efforts have been made by the person requesting the information to tell you about the request or to obtain an order protecting the disclosure of the information requested.

4. **Law Enforcement**: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (A) legal processes and otherwise required by law;(B) limited information requests for identification and location purposes;(C) pertaining to victims of a crime;(D) suspicion that death has occurred as a result of criminal conduct;(E) in the event that a crime occurs on the premises of any medical practice through which you are receiving care or treatment;and (F) medical emergency and it is likely that a crime has occurred.

5. **Research**: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

6. **Military Activity and National Security**: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (A) for activities deemed necessary by appropriate military command authorities; (B) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (C) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

7. **Workers' Compensation**: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

8. **Organ and Tissue Donation**: If you are an organ donor, we may disclose Protected Health Information about you to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ tissue donation and transplantation.

9. **Psychotherapy Notice**: We will not use or disclose Protected Health Information about you contained in psychotherapy notes without your authorization except for limited circumstances to carry out the following Treatment, Payment, or Health Care Operations: (a) use by the originator of the psychotherapy notes for Treatment; (b) use or disclosure by a health care provider in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; (3) use or disclosure by the Plan to defend a legal action or other proceeding brought by you against the Plan; or (d) as permitted by the applicable HIPAA regulations.

B. Permitted Disclosures to Family Members or Other Relatives Unless You Object

We may disclose PHI about you to family members, other relatives, and your close personal friends if: (a) the information is directly relevant to the family or friend's involvement with your care or payment for that care; and (b) you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

C. Disclosure Upon Your Request

Upon your request, we are required to give you access to certain Protected Health Information in order for you to inspect and copy it.

D. Other Uses of Your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us written authorization to use or disclose Protected Health Information about you, you may revoke that written authorization, in writing, at any time. If you revoke your written authorization, we will no longer use or disclose Protected Health Information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your written authorization.

E. Our Efforts to Safeguard Your Protected Health Information

CCT will implement processes and procedures in an effort to safeguard your protected health information including at least:

1. Limiting access to protected health information to the minimum number of CCT-staff members and/or vendors who need such access in the course of CCT operations;

2. Installing alarms and physical barriers in CCT facilities where such information is stored;

3. Limiting the number of people from CCT member entities who may have access to protected health information;

4. Conducting periodic training of CCT staff and Trustees on their responsibilities relative to protected health information; and

5. Requiring CCT vendors to execute agreements relative to their obligations pertaining to protected health information.

F. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as CCT maintains the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to have this decision reviewed. Please contact CCT's Privacy Officer if you have questions about access to your medical record.

2. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. CCT is not required to agree to a restriction that you may request. If CCT believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If CCT does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting CCT's Privacy Officer at the address, phone or fax number shown on the first page of this notice.

3. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to the Privacy Officer.

4. **You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as CCT maintains this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact the Privacy Officer to determine if you have questions about amending your CCT medical records.

5. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

6. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice electronically.

G. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by CCT. You may file a complaint with CCT by notifying the Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact the Privacy Officer at (p) 928.753.4700 or (f) 928.753.6767 for further information about the complaint process.

This amended notice was published and becomes effective on July 01, 2009.

ARTICLE XVII

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

This coverage is subject to the same deductibles and co-payments consistent with those established for other benefits under your plan.

ARTICLE XVIII

NOTICE OF PRESCRIPTION DRUG COVERAGE AND MEDICARE

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage available through Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage. You may ask for another copy of this notice from the Cochise Combined Trust (CCT) at any time. Key points for you to remember:

1. Medicare prescription drug coverage (sometimes called Medicare Part D) is available to everyone with Medicare.
2. The prescription drug coverage offered to you by CCT is generally better than the standard Medicare prescription drug coverage.
3. If you decide to keep your coverage through CCT's plan, you do not have to do anything.
4. If you keep your prescription drug coverage through CCT and then later decide to buy prescription drug coverage through Medicare, you will not have to pay a penalty (that is, pay a higher Medicare premium.)
5. If you have questions about this notice or would like more information about your coverage options, please contact your Personnel Office or Human Resources Department.

For the upcoming year you have several coverage options:

1. You may stay with your current plan offered by CCT. Because CCT's coverage is, on average for all plan participants, expected to pay out more than standard Medicare Part D prescription drug coverage will pay, you can keep this coverage and not pay a higher premium (that is, there is no penalty) if you later decide to enroll in a Medicare Part D plan. If you decide to keep your existing coverage through CCT's plan, you do not have to do anything. You will continue to be enrolled in CCT's plan and receive the same benefits you currently have.

2. You may enroll in a stand-alone Medicare prescription drug plan to obtain Medicare Part D coverage. All Medicare Prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

   If you want to enroll in a Medicare prescription drug plan, open enrollment for the Medicare prescription drug plans runs from November 15th through December 31st of each year. Before enrolling in a Medicare prescription drug plan, please contact your Personnel Office or Human Resources Department to discuss what health insurance coverage you have through CCT to avoid duplicate coverage.

   You should also know that if you drop or lose your prescription plan with CCT and don't enroll in a Medicare prescription drug plan or another plan that is at least as good within 63 days after your coverage with CCT ends, you will pay more (that is, pay a penalty) to enroll in Medicare prescription drug coverage. When you enroll in a Medicare prescription drug plan, your monthly premium will be increased at least 1% for every month you did not have coverage. For example, if you go 19 months without coverage, your premium for a Medicare prescription drug plan will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next November to enroll and until the next January to receive benefits.

3. You may decide not to have any prescription drug coverage from either CCT's plan or from a Medicare prescription drug plan. If you decide not to have any prescription drug coverage, you will have to pay a higher premium later (that is, pay a penalty), when you decide to enroll in a Medicare prescription drug plan. Later when you enroll in a Medicare prescription drug plan, your monthly premium will be increased at least 1% for every month you did not have coverage. For example, if you go 19 months without coverage, your premium for Medicare prescription drug plan will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until next November to enroll and until next January to receive benefits.

For more information about your current prescription drug coverage, please call the Prescription Customer Service number on your health insurance card.

If you have questions about this notice or would like more information about your options, please contact your Personnel Office or Human Resources Department.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook, which is published annually by Medicare. You will get a copy of the handbook in the mail from Medicare. You can also get more information about Medicare prescription drug plans from:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug plans is available. Information about this extra help can be obtained from the Social Security Administration (SSA) online at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

Keep this notice. If you enroll in a Medicare prescription drug plan in the future, you may need to give a copy of this notice to the plan to show that you are not required to pay a higher monthly premium. You may ask for another copy of this notice from CCT at any time.

Date:	July 01, 2009
Name of Entity/Sender:	Cochise Combined Trust
Address:	c/o Erin P. Collins & Associates, Inc. 1115 Stockton Hill Road, Suite 101 Kingman, Arizona 86401
Phone Number:	(928) 753-4700

ARTICLE XIX

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

STATEMENT OF RIGHTS

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., the Member's physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother and/or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). Pre-certification is still required for the delivery and for newborn placement in an intensive care nursery. Pre-certification is also required for any length of stay period in excess of the minimum (48 or 96 hours), even though not required for the minimum length of stay period.

COCHISE COMBINED TRUST

SIGNATURE PAGE

The preceding document has been accepted for use effective July 1, 2009

Date 5/4/09

For Cochise Combined Trust

Signature: _____

Title: Chairperson